

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE New York		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bethesda, (Rural)		LENGTH OF STAY (in this place) 18 days		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bronx			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital, Bethesda, Md.				STREET ADDRESS (If rural, give location) 3454 Fentor Street			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) JEROME		(Middle) BERNARD		(Last) AEOLIAN		(Month) (Day) (Year) March 17 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 8 Sept. 1930		9. AGE last birthday: 25 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): USMC		10b. KIND OF BUSINESS OR INDUSTRY: USMC		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: LEON AEOLIAN				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: New York City, N.Y. (Sister) Mrs. Paula KRITZ, 1803 Riverside Dr.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							22 days
Immediate cause		(a) Cerebral hemorrhage & laceration					
Antecedent cause(s)		(b) Communited fracture of skull (depressed)					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Street		21c. (City or town) Washington D.C.		21d. (County) N.C.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 2-24-56 12:00 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Driver failed which struck buttrest of car			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Frank J. Brothman		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		DATE SIGNED 3-18-56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 3-20-56		NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		LOCATION (City, town, or county) (State) Brooklyn, New York	
DATE REC'D BY LOCAL REG. 18 March 1956		REGISTRAR'S SIGNATURE Mary E. Parrelly		24. FUNERAL DIRECTOR R.A. PUMPHREY, 7557 Wisconsin Ave.,		ADDRESS Bethesda, Md.	

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BUREAU V. S.

MAR 21 1936

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STANDARD, NEW YORK
BUREAU, NEW YORK
MAR 21 1936

STANDARD, NEW YORK

STANDARD, NEW YORK

MAR 21 1936

3023

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY 18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						d. STREET ADDRESS 21 Levin Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Belle ALLEN						4. DATE OF DEATH Month Day Year March 17 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Sept. 1926		9. AGE (In years last birthday) 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Ernest WARREN						14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Lexington Park, Md. (Husband) William E. ALLEN, 21 Levin Drive,					
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 26 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 March 1956 to 17 March 1956 , that I last saw the deceased alive on 17 March 1956 , and that death occurred at 1835 M., from the causes and on the date stated above.									
ACTUAL SIGNATURE Robert W. Mackie				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-19-56					
PHYSICIAN'S NAME (Type) Robert W. MACKIE, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 22 March 1956		22c. NAME OF CEMETERY OR CREMATORY Providence		22d. LOCATION (City, town, or county) (State) Liberty Clay Co. Missouri			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS R.A. PUMPHREY FUNERAL HOME 7557 WISCONSIN Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Bary E. Tarsally	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAR 13 1956

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18222 Film 619-3-10-55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8915 Georgia Ave</u>				STREET ADDRESS (If rural, give location) <u>8915 Georgia Ave</u>			
3. NAME OF DECEASED: (First) <u>Fredrick</u> (Middle) <u>Theodore</u> (Last) <u>Arends</u>				4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>SEPT. 24, 1938</u>	
				9. AGE last birthday: <u>17</u> yrs.		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student at Montgomery Blair High</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>WASHINGTON, DC.</u>		11. BIRTHPLACE (State or foreign country): <u>WASHINGTON, DC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>THEODORE GEORGE ARENDS</u>				14. MOTHER'S MAIDEN NAME: <u>LOUISE VOGEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>THEODORE G. ARENDS, 8915 GA.AVE., SS., MD.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>972x</u> Immediate cause (a) <u>Asphyxia due to lack of oxygen</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>Found dead</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Silver Spring Montg md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-4-56 8 A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Found dead with illuminating gas tube in mouth</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Borchert</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-4-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>MARCH 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	
LOCATION (City, town, or county) (State) <u>SUITLAND, PR. GEO. CO. MD.</u>		24. FUNERAL DIRECTOR <u>Waxmax E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
DATE REC'D BY LOCAL REG. <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

9 MAR 6 1956

RECEIVED

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Infant boy		Male		1 year		1955		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Sudden infant death		Accident		None		None		None	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
1956		10:00 AM		Home		Dr. J. H. Smith		None	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 8 1956

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302

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bailey</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 14, 1887</u>		9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charlie Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Nell Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO (b) <u>Second degree burns of head + arms</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped from 2nd floor of burning home</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>3-20-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Cooksville Howard Co</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-20-56</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>5-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Hopkin Medical School - St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>St. Johns Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>				24a. REC'D BY REGISTRAR DATE <u>5/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>Beatrice B. Lawler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Only delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

W. A. L. 1740

MAY 15 1956



3028

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN lb 2 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.			
d. STREET ADDRESS 2917 Bellview Terrace, N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First Sarge		Middle BALL		Last	
4. DATE OF DEATH Month March Day 25 Year 1956		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 6 1869		9. AGE (In years last birthday) yrs 86		10. IF UNDER 1 YEAR Months 25 Days 25 Hours 19 Min. 56		11. BIRTHPLACE (State or foreign country) Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John A. BALL				14. MOTHER'S MAIDEN NAME Elizabeth DIRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT C.R. BALL, Capt. MC, USN (Son)		Address 2-D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage DUE TO Cause unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown (c) Cause unknown						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince George Co. Maryland		20g. (State) Maryland		20h. (County) Prince George Co.	
21. I certify that I attended the deceased from 23 March , 19 56 , to 25 March , 19 56 , that I last saw the deceased alive on 25 March , 19 56 , and that death occurred at 7:20A AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gerald I. Plitman		M.D. U.S. NAVAL HOSPITAL, BETHESDA, MD.		DATE SIGNED 3-26-56		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) Gerald I. PLITMAN, LT, MC, USN		U.S. NAVAL HOSPITAL, BETHESDA, MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3-27-56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) Prince George Co. Maryland		22e. (State) Maryland		22f. (County) Prince George Co.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY		ADDRESS Bethesda, Md. 7557 Wisconsin Ave.,		24a. REC'D BY REGISTRAR 3-26-56		24b. REGISTRAR'S SIGNATURE Mary E. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7 A 1000

29.10.1944

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>35 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
f. STREET ADDRESS <u>903 Fairview Ave.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Hayward Beall</u>		4. DATE OF DEATH <u>3-25-1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-20</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Equipment Specialist Naval Gun Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hayward Beall</u>		14. MOTHER'S MAIDEN NAME <u>Cecille Chisolm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Wife - Mrs Bettie Beall</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture Aneurysm Basilar Artery</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>factory, street, office bldg., etc.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1952</u> , to <u>3-25-1956</u> , that I last saw the deceased alive on <u>3-25-1956</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N.C. Shoemaker M.D.</u>		ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive</u>	
PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER, M.D.</u>		DATE SIGNED <u>Delaware Springs, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Miss Funeral Home</u>		ADDRESS <u>3605-14th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>3/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3029

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
c. LENGTH OF STAY IN 1b <i>1 month</i>		d. STREET ADDRESS <i>5426 Calhoun Rd. N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>—</i> Last <i>Beck</i>		4. DATE OF DEATH Month <i>March</i> Day <i>9th</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 8, 1868</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Food Products Sales Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BALTIMORE, MARYLAND</i>	
11. BIRTHPLACE (State or foreign country) <i>71</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George H. Beck</i>		14. MOTHER'S MAIDEN NAME <i>Ida Bolleman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT Address <i>Mr. DeLebay 115 W. Saratoga St</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> (c) <i>Extensive 2° Burns of Skin</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i> <i>20 years</i> <i>36 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Adenocarcinoma of Prostate</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Feb. 2 1956</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 2</i> , 1956, to <i>March 8</i> , 1956, that I last saw the deceased alive on <i>March 8</i> , 1956, and that death occurred at <i>3:40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. McCann</i> M.D.		ADDRESS (Street, city or town, state) <i>809 Viera Mill Rd. Rockville Md.</i>	
PHYSICIAN'S NAME (Type) <i>Rockville Md.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/12/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Inc.</i>		ADDRESS <i>1217 St. Paul St. Baltimore</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Samuel H. Heston</i>	
DATE <i>—</i>		<i>May 8, 1956</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 15 1960

U.S. DEPARTMENT OF AGRICULTURE

3030

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7816 Stratford Road				d. STREET ADDRESS 7816 Stratford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Daisy Middle M. Last BECKER				4. DATE OF DEATH Month March Day 26 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1884		9. AGE (In years last birthday) yrs 71	IF UNDER 1 YEAR Months 10 Days 17	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. Birkle				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edmund H. Becker, Jr. 4821 N. Lane, Beth. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of urinary bladder DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 months 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1949 to March 25, 1956 , that I last saw the deceased alive on March 25, 1956 , and that death occurred at 2:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace M. Yater				M.D. 1801 K St., N.W., Washington 6, D.C. DATE SIGNED 3/26/56			
PHYSICIAN'S NAME (Type) Wallace M. Yater, M. D.				1801 K St. N. W. Washington, D. C. 3/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-28-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

376 (11)

3031

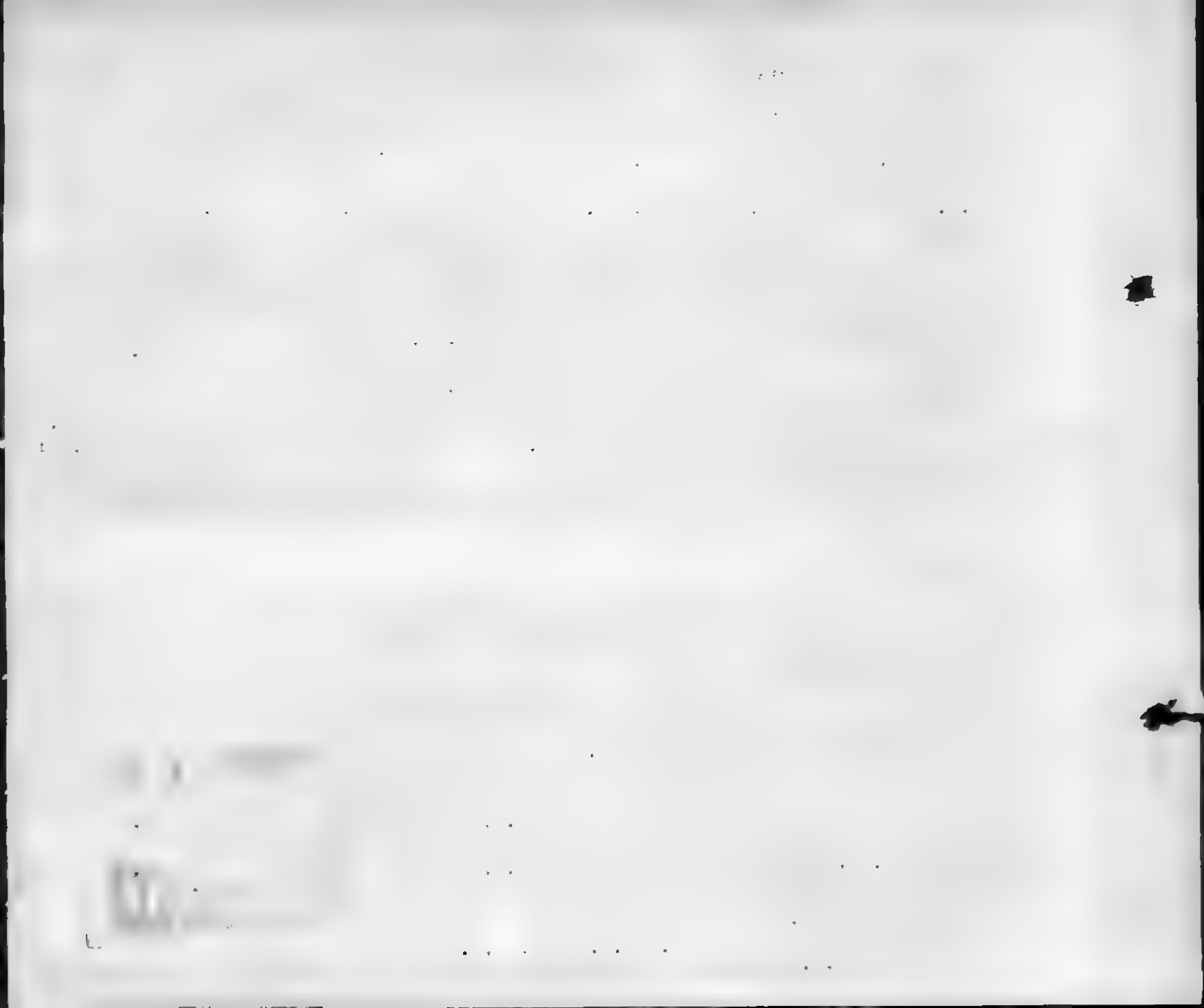
CERTIFICATE OF DEATH

02971

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Port Deposit</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, (rural)</u>				c. LENGTH OF STAY IN 1b <u>1 Mo. 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>30 Henley Pkwy, Manor Hgts.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Feltie</u> Last <u>BELK</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 June 1905</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mariner</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Deceased</u>				14. MOTHER'S MAIDEN NAME <u>Minnie RONE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Bethesda, Md.</u> <u>Mrs. Berenice BELK, 4710 Edgemoor Lane, Apt. 201</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine carcinoma (primary at cervix)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8 Feb.</u> , 19 <u>56</u> , to <u>12 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 March</u> , 19 <u>56</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>E. J. RUPNIK</u>							
ACTUAL SIGNATURE <u>E. J. RUPNIK</u>				PHYSICIAN'S NAME (Type) <u>E. J. RUPNIK, LCDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>16 Mar. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. HINES</u>				24a. REC'D BY REGISTRAR <u>St., N.W. Wash. D.C.</u> <u>2901 14th</u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. Steadley</u>				24c. REGISTRAR'S SIGNATURE <u>W. H. Steadley</u>			



3032

CERTIFICATE OF DEATH

Reg. Dist. No.

02972
216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7207 Lenhart Dr.		e. STREET ADDRESS 7207 Lenhart Dr.	
3. NAME OF DECEASED (Type or print) Anna Weyhe Bertelsen		4. DATE OF DEATH March 3, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 12, 1866
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Lemvig, Denmark	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Christian W. Bertelsen-		Address 224 Mt. Vernon St. Dedham, Mass.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4444 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coro-Vascular Renal Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 Days 6 Months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1955 to Mar. 3, 1956 , that I last saw the deceased alive on March 3, 1956 , and that death occurred at 8:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold Heiges M.D.		ADDRESS (Street, city or town, state) 1835 Eyst NW DC	
DATE SIGNED 3/3/56			
PHYSICIAN'S NAME (Type) H. H. Heiges M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/6/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	22d. LOCATION (C'ty, town, or county) (State) Prince Georges Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co. Washington 9, D.C.		ADDRESS	24a. REC'D BY REGISTRAR DATE 8-7-56
		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANLEY A. B.

19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
→ 3033
CERTIFICATE OF DEATH

02973

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4300 Lynbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Winfield</u> First Middle Last 4. DATE OF DEATH Month Day Year <u>March 26 1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 3, 1902</u> 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days <u>8 23</u> IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist - Dist. Manager Peoples Drug Stores</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland, Ohio</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frances Marion Bond</u> 14. MOTHER'S MAIDEN NAME <u>Sadie Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>577-05-9283</u> 17. INFORMANT <u>Wife - Fern B. Bond</u> Address <u>above</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction acute</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5+ years</u> DUE TO <u>arteriosclerosis generalized</u> (c) <u>10+ years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/26/1956</u> to <u>3/26/1956</u> that I last saw the deceased alive on <u>3/26</u> 19 <u>56</u> and that death occurred at <u>8:00 AM</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>4861 BATTERY LANE</u> DATE SIGNED <u>3/26/56</u> ACTUAL SIGNATURE <u>Charles J. Savarese, Jr. M.D.</u> PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR. M.D. BETHESDA, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4619 Chase Ave.		d. STREET ADDRESS 4619 Chase Avenue	
3. NAME OF DECEASED (Type or print) First MINNIE Middle E. Last BOOTH E		4. DATE OF DEATH March 8, 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) N. Carolina
13. FATHER'S NAME Wilson Godfrey		14. MOTHER'S MAIDEN NAME Julia A. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. C. Simmons-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis + 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) congestive heart failure (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH years 3 months several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month/Day/Year 11/45 p.m. 3/9 1956	20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/1, 1955 , to 3/9, 1956 , that I last saw the deceased alive on 3/8, 1956 , and that death occurred at 11:45 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Allen J. O'Neill		ADDRESS (Street, city or town, state) 7771 Old Georgetown Rd, Bethesda	
PHYSICIAN'S NAME (Type) Allen J. O'Neill		DATE SIGNED March 10, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3-11-56	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Hollywood	22d. LOCATION (City, town, or county) (State) Elizabeth City, N. Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-12-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

Dr. Brockett asked for proper procedure
in this situation: i.e. Dr. Savarese, the
usual attending physician being out of town
for 10 days, and the death pronouncement
being made by a physician from the
District of Columbia who does not have
a Maryland license. Under these circumstances
and since the patient was recently in Johns Hopkins
Hospital for a month in the critical
condition for death, I was advised to sign the ^{certificate} ~~death~~ ^{to} ~~the~~ ^{new} ~~ind.~~

CERTIFICATE OF DEATH

Reg. Dist. No. 223

2986

1. PLACE OF DEATH a. COUNTY <i>Mountgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> c. LENGTH OF STAY IN 1b <i>5 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington-Sinclair Hospital</i>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY <i>Dumont</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>11 Niagara St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs Elizabeth Beitelmann</i>		4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 19 - 1876</i>
9. AGE (In years last birthday) <i>79 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
13. FATHER'S NAME <i>John Beitelmann</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Hambricht</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic H. Disease</i> DUE TO (c) <i>None</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Recent Times Depression followed by Depression</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 26</i> , 1956, to <i>Mar. 26</i> , 1956, that I last saw the deceased alive on <i>Mar. 26</i> , 1956, and that death occurred at <i>11:55</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry E. Anderson</i>		DATE SIGNED <i>Mar. 26</i>	
PHYSICIAN'S NAME (Type) <i>Henry E. Anderson M.D.</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Park Takoma Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/27/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Leacock Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Leacock Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Baulewicz</i>		ADDRESS <i>1733 Pa. Avenue</i>	
24a. REC'D BY REGISTRAR <i>DATE 3/28/56</i>		24b. REGISTRAR'S SIGNATURE <i>John D. Bell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		c. LENGTH OF STAY IN 1b 118 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 10 E. Henrietta Street	
3. NAME OF DECEASED (Type or print) Joseph Franklyn Bowden		4. DATE OF DEATH March 16, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1933
9. AGE (In years last birthday) 23		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gas & Light	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bowden		14. MOTHER'S MAIDEN NAME Stella Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-28-0979	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3 Bleeding from Traumatic-esophageal fistula DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 19, 1955 , to March 16, 1956 , that I last saw the deceased alive on March 16, 1956 , and that death occurred at 7:45 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE Claude E. Forkner (as per Dr. John Tarter)		DATE SIGNED March 16, 1956	
PRINTED NAME (Type) Claude E. Forkner, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/56	22c. NAME OF CEMETERY OR CREMATORY Glen Haven	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, Inc. 715 Light St.		24a. REC'D BY REGISTRAR March 17, 1956	
		24b. REGISTRAR'S SIGNATURE R. W. Mary E. Farrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1956

RECEIVED

02977

CERTIFICATE OF DEATH

2987

Reg. Dist. No. 223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TAKOMA PARK</u>	LENGTH OF STAY (in this place) <u>80 DAYS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON, DC</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>700-HUDSON AVE.</u>		STREET ADDRESS (If rural give location) <u>306-EMERSON ST. N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>GOLDIE</u> (Middle) <u>BOZIN</u> (Last) <u>BOZIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 2, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>?</u>
9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABE BRILLMAN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	
17. INFORMANT & ADDRESS <u>SAMUEL BOZIN - 306 EMERSON ST. N.W. DC</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>RENAL FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>MALIGNANT HYPERTENSION</u>			<u>UNKNOWN</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CEREBRAL ATROPHY</u>			<u>2 H. WITH S</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 27, 1956</u> to <u>MAR 2, 1956</u> , that I last saw the deceased alive on <u>MAR 2, 1956</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Arthur J. Brinkman</u> M.D.		ADDRESS (Street, city, town, state) <u>533 P St. N.W. Wash. D.C.</u>	
DATE SIGNED <u>3-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL - BURIAL</u>		DATE THEREOF <u>3/4/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>GOODMAN-BOWSMAN FUNK. HOME</u>		LOCATION (City, town, or county) (State) <u>MILWAUKEE Wisc.</u>	
24. REC'D BY REGISTRAR <u>Richard Kroll</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Shelley Funeral Home</u>	
DATE <u>3-5-56</u>		ADDRESS <u>4217-9th Ave. N.E.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 1324 Staples Street, N.E.			
e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ernest Middle Blake Last BRYANT				4. DATE OF DEATH Month March Day 23 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-94	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jucius BRYANT				14. MOTHER'S MAIDEN NAME Elizabeth JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Friend Mrs. Lucille M. HARLEY Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Syphilis, Cardiovascular & cardiomegaly (c) Nephrosclerosis & uremia						INTERVAL BETWEEN ONSET AND DEATH 12 hrs 18 mos 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (d) Bronchopneumonia due to Staphylococcus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 Dec , 19 55 , to 23 Mar , 19 56 , that I last saw the deceased alive on 23 Mar , 19 56 , and that death occurred at 1:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Maryland DATE SIGNED							
ACTUAL SIGNATURE J. T. Horgan LT, MC, USN , USNH, NNMC, Bethesda, Maryland							
PHYSICIAN'S NAME (Type) J. T. HORGAN LT, MC, USN , USNH, NNMC, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28 Mar 56		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 4th and Mass Ave NE, Wash, D.C.				24a. REC'D BY REGISTRAR DATE 23 Mar 56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completed by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. V. S.

1942

3037

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 121 Peabody Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William George BUCHANAN		4. DATE OF DEATH Month Day Year March 10 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-77
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY Mariner Retired	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John BUCHANAN		14. MOTHER'S MAIDEN NAME Agnes RHOMESON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Wife Mrs. Nadine B. BUCHANAN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emboli		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Feb 1956 to 10 Mar 1956 , that I last saw the deceased alive on 10 Mar 1956 , and that death occurred at 7:50A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE R. G. Williams M.D. USNH, NNMC, Bethesda, Maryland			
PHYSICIAN'S NAME (Type) R. G. WILLIAMS LCDR USN (MC) USNH, NNMC, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 14 Mar 56	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Co Hill ADDRESS HINES Funeral Home, 2901 14th Street, N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 10 Mar 56 24b. REGISTRAR'S SIGNATURE Mary E. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After it is signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3038

CERTIFICATE OF DEATH

02980

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100		d. STREET ADDRESS 6810 GLENBROOK RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSIA Middle BURCH Last BURCH		4. DATE OF DEATH 3-24 19 56	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-73
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 82 Days 82 Hours 82 Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY KENTUCKY	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME STEVE BURCH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not. no. or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO FRED H. UGAST 6810 GLENBROOK RD.	
17. INFORMANT FRED H. UGAST		Address 6810 GLENBROOK RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure, acute DUE TO Hypertension, essential, severe DUE TO Arteriosclerosis, generalised Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Left hemiplegia 2.3.56 & Bronchopneumonia left lung			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 yrs + 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left hemiplegia 2.3.56 & Bronchopneumonia left lung			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-16-1956 , to 3-24-1956 , that I last saw the deceased alive on 3-24-1956 , and that death occurred at 5:30 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) Wash D.C. DATE SIGNED 3-24-56	
PHYSICIAN'S NAME (Type) Stewart Clapp M.D.		M.D. 3921 Ingomar St N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/56	
22c. NAME OF CEMETERY OR CREMATORY mt Olney		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis G. Hallin		ADDRESS 3821-14th NW	
24a. REC'D BY REGISTRAR DATE 8-27-56		24b. REGISTRAR'S SIGNATURE Benjamin Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02981
Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>826 Crothers Lane</u>				STREET ADDRESS (If rural, give location) <u>826 Crothers Lane</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Stephen Patrick Burgess</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 4 1956</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>11-17-55</u>	
9. AGE Last birthday: <u>3</u> yrs. <u>3</u> Months <u>29</u> Days <u>29</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Harold Burgess</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary Catherine Campbell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY No.: <u>no</u>				17. INFORMANT & ADDRESS: <u>Walter Burgess (father) Same as Decd.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Asphyxia due to vomiting</u> DUE TO Antecedent cause(s) (b) <u>Upper Respiratory Infection</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Found dead in bed.</u>	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				(State)			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		21g. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James J. Broschait</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-4-56</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>3/7/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bryant</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

3 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Olney				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1 - Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Jackson Last Burriss				4. DATE OF DEATH Month Mar Day 23 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/15/1872	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER & TENANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Burriss				14. MOTHER'S MAIDEN NAME Unknown by Family			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Daughter		Address Same As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 703.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) fracture of Neck of lt. femur (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on Floor At Home			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/18 19 56 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) RT. #1, Silver Spring, Mont	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY	
				22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3	
				24b. REGISTRAR'S SIGNATURE Bertine B. Lowry			

RECEIVED

APR 4 1956

RECEIVED

3040

CERTIFICATE OF DEATH

02983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Potomac				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Potomac			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. # 3, Bethesda.				d. STREET ADDRESS R. F. D. # 3 Bethesda			
3. NAME OF DECEASED (Type or print) First CHARLES Middle S. Last CASE				4. DATE OF DEATH Month March Day 25, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1984		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 10 Days 29 Hours Mins. 	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.			10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles A. Case				14. MOTHER'S MAIDEN NAME Emma D. Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT J. B. Case- Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - coronari DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 min Indef Indef	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3/12/56 , to 3/25/56 , that I last saw the deceased alive on 3/25/56 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D. Robert A. Pumphrey				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 3/26/56			
PHYSICIAN'S NAME (Type) Stephen N. Jones- Rockville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 3-28-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

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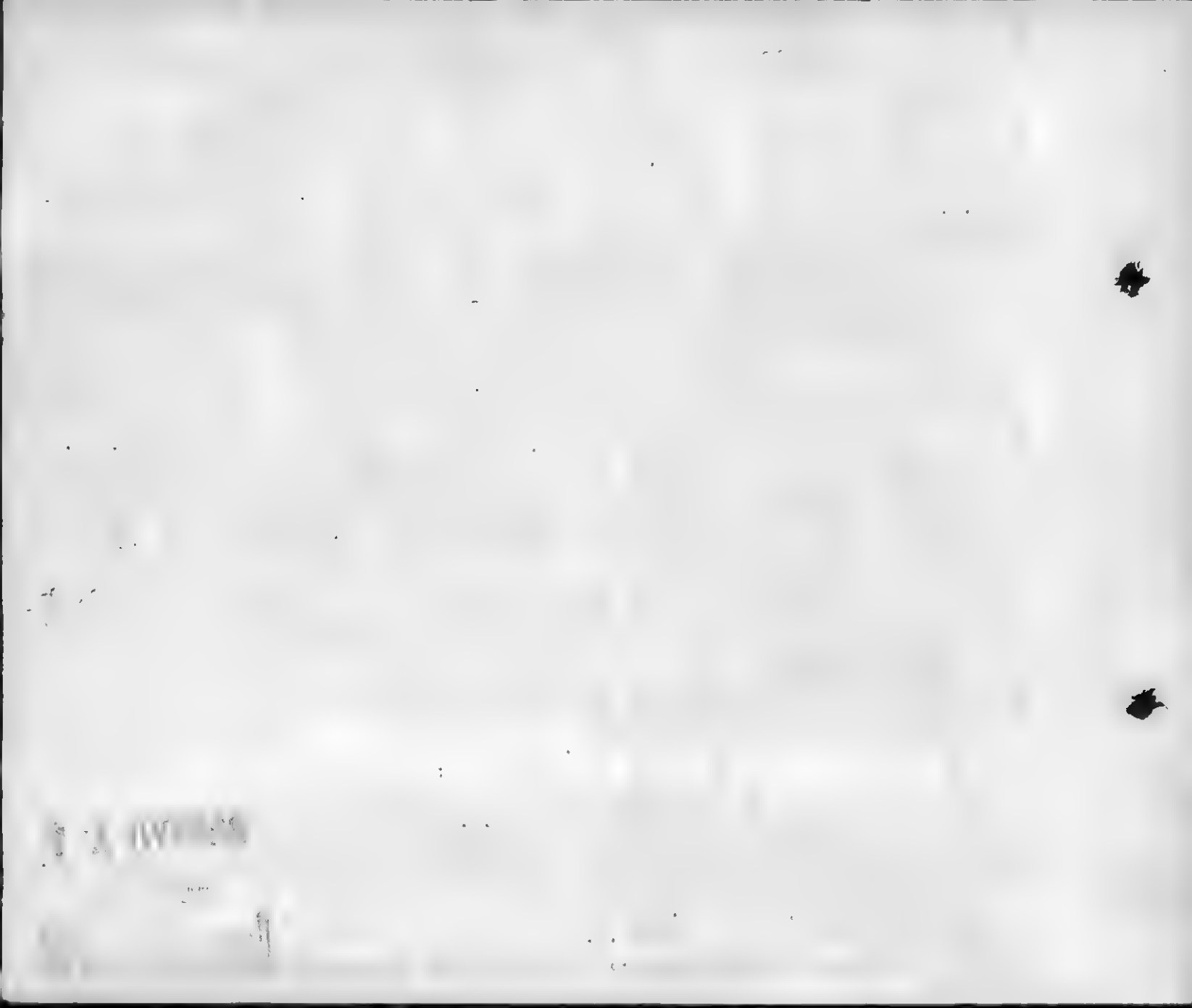
3041

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NHC</u>				d. STREET ADDRESS <u>2418 Homestead Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Kathleen</u> Middle <u>(n)</u> Last <u>CATRAMONE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-55</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James CATRAMONE</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth COLLINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>MS. Elizabeth CATRAMONE</u> Address <u>2418 Homestead Drive, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4.2</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Patent ductus</u> DUE TO <u>Congenital heart disease - i.e. septal defect</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>3 1/2 mo</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>11 Feb.</u> , 19 <u>56</u> , to <u>11 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 March</u> , 19 <u>56</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Howard A. Pearson</u> M.D.				ADDRESS <u>U.S. Naval Hospital, NHC, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD A. PEARSON, M.D., M.C., M.C.</u>				ADDRESS <u>U.S. Naval Hospital, NHC, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 Mar. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Evangelist Parish</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u>				ADDRESS <u>U.E. P. H. H.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Barclay</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS 15 (4)
ISM 9/SS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3043

CERTIFICATE OF DEATH

Reg. Dist. No. 2286

02986

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lesley Middle Taley Last Compton		4. DATE OF DEATH Month March Day 9 Year 1956	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1916
9. AGE (In years for birthday) yrs. 40		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry Taley		14. MOTHER'S MAIDEN NAME Leslie Baxter Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 526-26-9557	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inability to open aortic valve at surgery + heart fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Pneumatic Heart Disease - inactive & aortic stenosis DUE TO (c) Congenital Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 14 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severity of Calcification of valve.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9:41 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 22, 1956 , to March 9, 1956 , that I last saw the deceased alive on March 9, 1956 , and that death occurred at 12:30AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward H Sharp, M.D.		DATE SIGNED 3/9/56	
PHYSICIAN'S NAME (Type) Edward H. Sharp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-10-56	22c. NAME OF CEMETERY OR CREMATORY Ft. Barrancas Nat. Cem.	22d. LOCATION (City, town, or county) (State) Pensacola - Escambia Florida
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 3-10-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1950

Item 12, Certificate of Death

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Landoner Hills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmore San. 5721 Grosvenor Lane</u>		STREET ADDRESS (If rural give location) <u>6708 Redfield Ave.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Fernando Cosgrove</u>		OF DEATH: <u>3</u> <u>1</u> <u>1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Legally Separated</u>	8. DATE OF BIRTH: <u>6-28-1894</u>
		9. AGE last birthday <u>63</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Governess</u>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>France</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME: <u>JULES LECONTE</u>	14. MOTHER'S MAIDEN NAME: <u>Emma Monogdin</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>723-16-4924</u>
17. INFORMANT & ADDRESS: <u>Edward Cosgrove - 6708 Redfield Ave., Landoner Hills, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE DUE TO <u>Respiratory Failure</u>		<u>8 hrs</u>
(B) ANTECEDENT CAUSE (S) DUE TO <u>Renalized metastasis</u>		<u>3 months</u>
(C) DUE TO <u>Retention of all System of Ovary with living</u>		<u>2 months</u>
(D) DUE TO <u>Acute fibrous degeneration</u>		<u>4 hrs</u>
(E) DUE TO <u>Diabetic mellitus</u>		<u>8 hrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Simple gutta & thyroid</u>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July, 1954, to 3, 1956, that I last saw the deceased alive on 23/1, 1956, and that death occurred at 11:55 A M, from the causes and on the date stated above.

23. BURIAL CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>3/1/56</u>	<u>---</u>	<u>Mt. Rainier, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>3-1-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Valleys Funeral Home Inc 3200 K. Island Ave. Mt. Rainier, Md.</u>
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BUREAU V. S.

MAR 5 1956

RECEIVED

3045

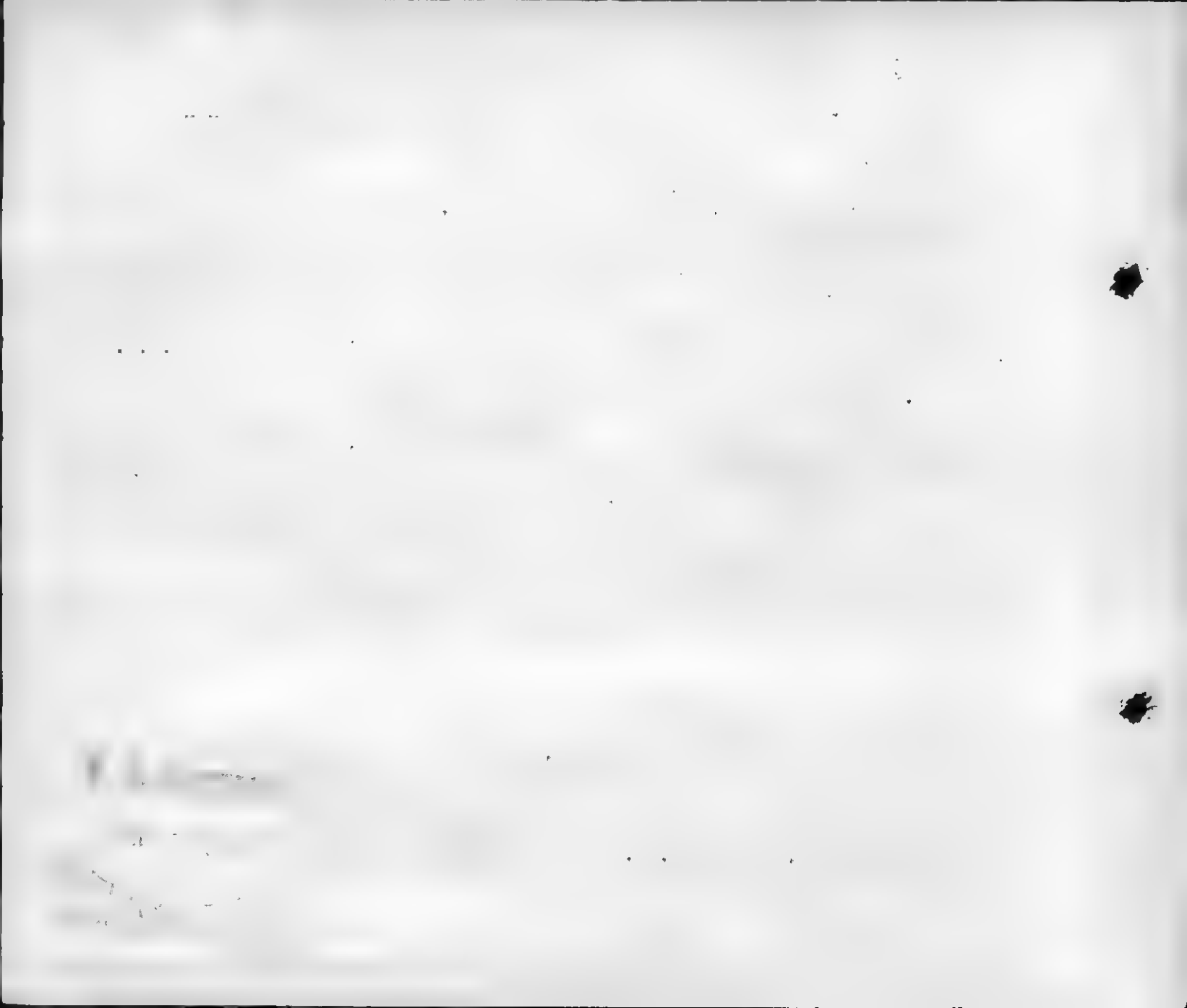
CERTIFICATE OF DEATH

02988

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY - -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health				d. STREET ADDRESS 208 S. Saluda Avenue			
3. NAME OF DECEASED (Type or print) First William Middle David Last Crenshaw				4. DATE OF DEATH Month March Day 14 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1896	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 9 Days 29 Hours - Min. -		IF UNDER 24 HRS. Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper foreman				10b. KIND OF BUSINESS OR INDUSTRY Publishing		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W. Crenshaw				14. MOTHER'S MAIDEN NAME Jenny Galloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The medical record, The Clinical Center	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) New bacillus septimaria & interstitial emphysema of chest & face DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 5, 1956 , to March 14, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/15/56 ACTUAL SIGNATURE Herbert J. Levine M.D. M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Herbert J. Levine, M. D. Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 3-14-56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Columbia So. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 3-16-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2988
CERTIFICATE OF DEATH

02989

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington and Lee Hospital</u>				d. STREET ADDRESS <u>10014 Dallas Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mr Ferdinand</u> Middle <u>Joseph</u> Last <u>Grovato</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28 1907</u>	
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mech. Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. - New Jersey</u>	
13. FATHER'S NAME <u>Samuel Grovato</u>				14. MOTHER'S MAIDEN NAME <u>Erminia (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho-pneumonia</u>							
151X DUE TO (b) <u>Carcinoma of liver</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Carcinoma of stomach</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operation & Exploratory Laparotomy & Liver biopsy 3-6-56</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>March 5, 1956</u> to <u>March 14, 1956</u> that I last saw the deceased alive on <u>March 11, 1956</u> , and that death occurred at <u>4:21 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Read N. Calvert, M.D.</u>				ADDRESS (Street, city or town, state) <u>7894 Georgia Ave, Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery Forest Glen, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haddon - 3831 - 86th St N.W.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3-15-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>John P. Dadd</u>			

BUREAU V. B.

MAR 16 1956

RECEIVED

RECEIVED
MAR 16 1956
BUREAU V. B.

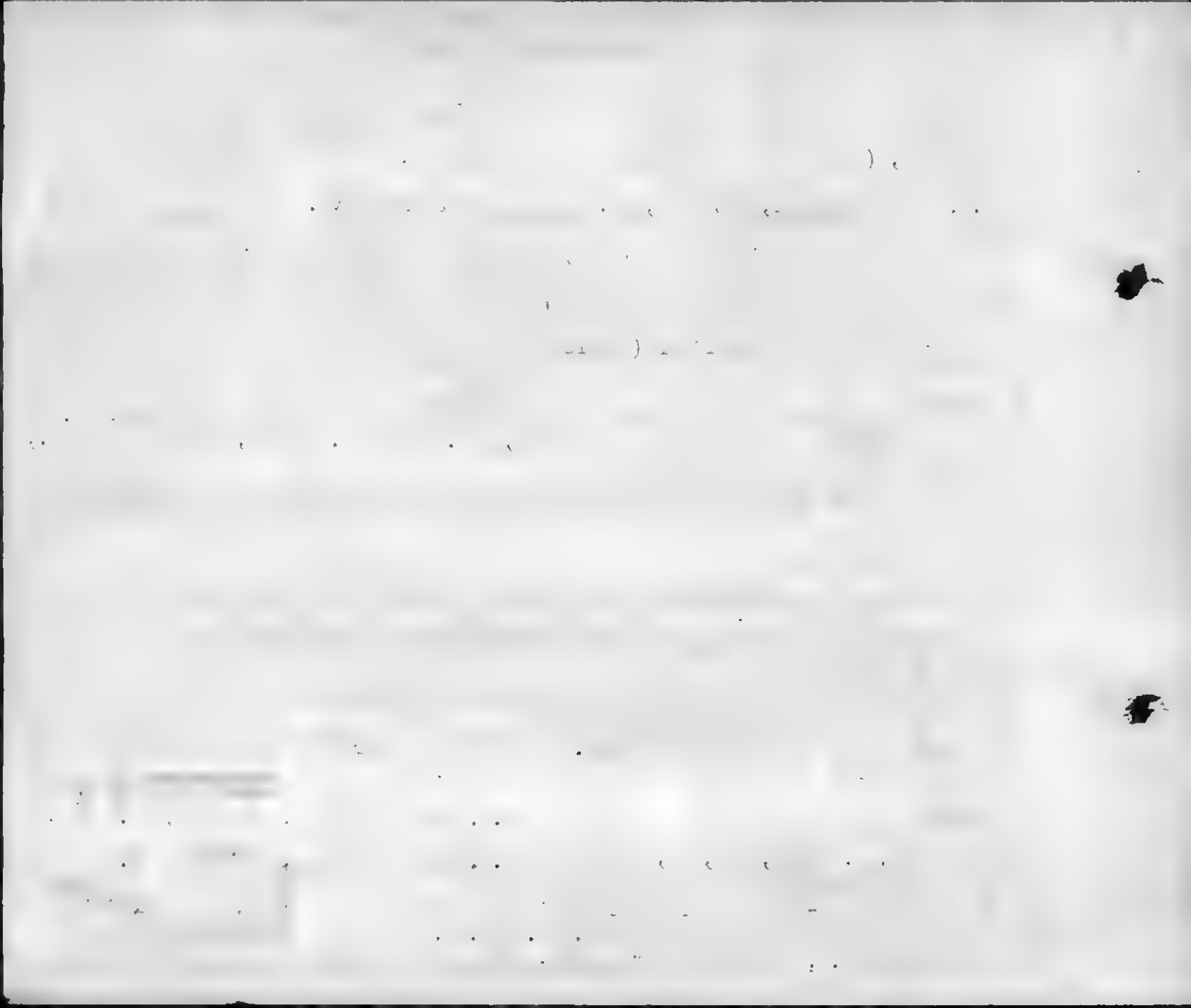
3046

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle (none) Last CUKELA		4. DATE OF DEATH Month March Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 May 1888
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY Mariner (Retired)	
11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1&2		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT (Wife) Mrs. Minnie S. CUKELA		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, Lungs and Adrenals DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Saenmec's Virus, Atherosclerosis, Arterio Nephrosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Feb. 19 56 , to 19 March 19 56 , that I last saw the deceased alive on 19 March 19 56 , and that death occurred at 2:45P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. R. Davis		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-20-56	
PHYSICIAN'S NAME (Type) J. R. DAVIS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-22-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Wisc. Ave. Beth. Md.	
DATE 3-20-56		24. REGISTRAR'S SIGNATURE Mary E. Tasselly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

02991

Reg. Dist. No. 216

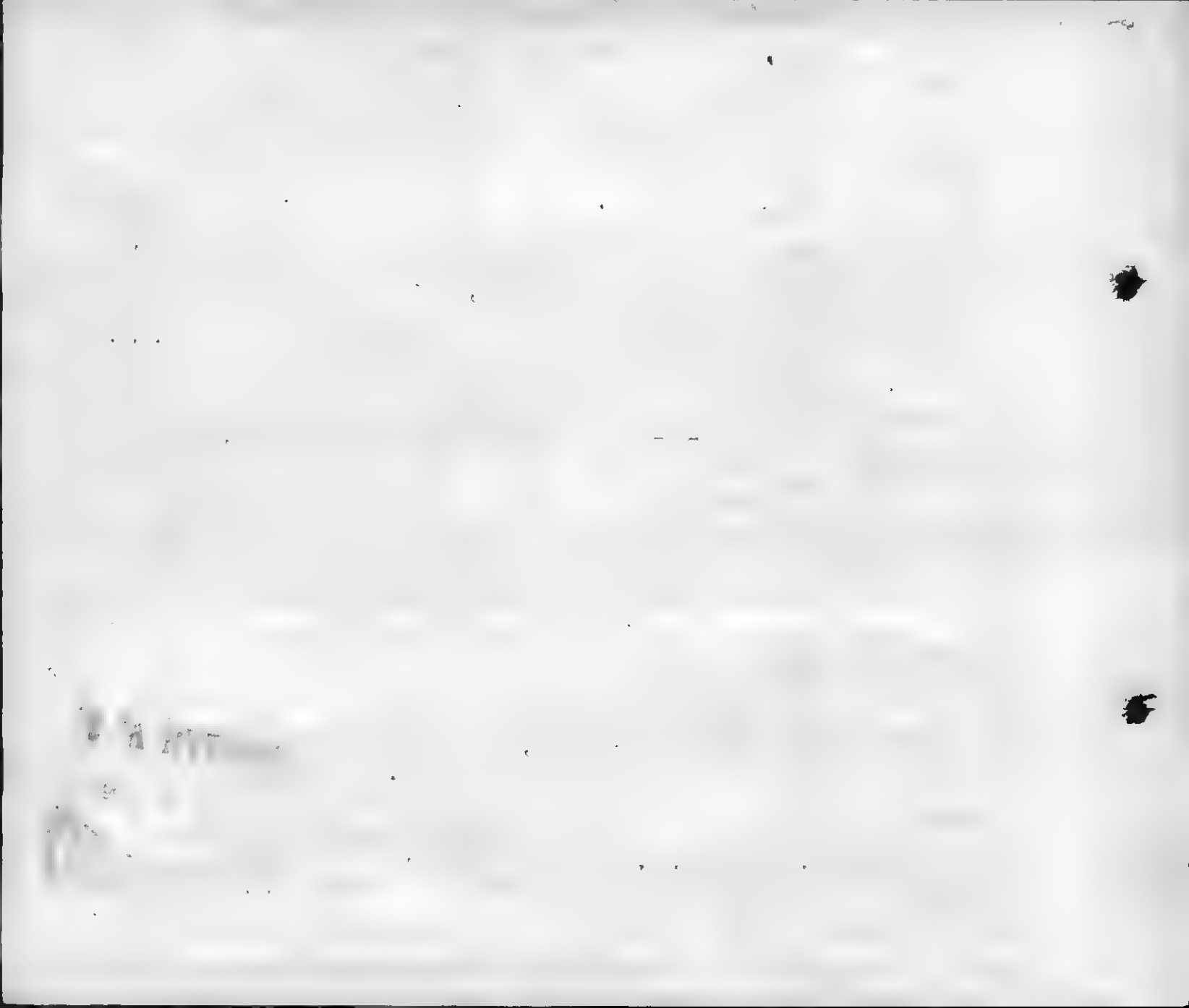
3047

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.		d. STREET ADDRESS no street address	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle William Last Cullember		4. DATE OF DEATH Month March Day 20 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1903
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Cullember		14. MOTHER'S MAIDEN NAME Margaret Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-34-8605	
17. INFORMANT The Medical Record Address		The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Calcific Aortic Stenosis, postoperative DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemopericardium			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 12, 1956 to March 20, 1956 , that I last saw the deceased alive on March 20, 1956 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Kaiser		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) George C. Kaiser, M. D.		DATE SIGNED 3/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/56	
22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		22d. LOCATION (City, town, or county) (State) Lothian Md	
23. FUNERAL DIRECTOR'S SIGNATURE Th P Hutchins		ADDRESS Owings	
24a. REC'D BY REGISTRAR Benie M. Thompson		DATE 3/22/56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BROOKE GROVE CONVALESCENT HOME				d. STREET ADDRESS 9707 LAWDALE DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MELVIN Middle A. Last CUMMINGS				4. DATE OF DEATH Month Mar. Day 15 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1864	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER S. CUMMINGS				14. MOTHER'S MAIDEN NAME MARY BARLOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ARTHUR M. CUMMINGS, 9707 LAWDALE DRIVE SILVER SPRING MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (recurrent) 8 nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 14 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 32 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb'y , 1955, to Mar 15 , 1956, that I last saw the deceased alive on Feb'y 13 , 1956, and that death occurred at 5:55 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John N. Andrews		M.D. 9601 Coleville Rd. Silver Spring Md		DATE SIGNED 3-16-56			
PHYSICIAN'S NAME (Type) John N. Andrews, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 3/19/56		22c. NAME OF CEMETERY OR CREMATORY FOWLER CEMETERY		22d. LOCATION (City, town, or county) (State) FOWLER, MEADE COUNTY, KANSAS	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3-17-56	
						24b. REGISTRAR'S SIGNATURE Centred B Fowler	

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BUREAU A. J.

govt

RECEIVED

3049

CERTIFICATE OF DEATH

02993

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IS <u>6 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3915 Ingomar St. NW</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>May</u> Last <u>Cutcheon</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-68</u>
9. AGE (In years last birthday) <u>87 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles ARMOR</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Klotter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Burgess, Herbert</u> Address <u>1523 Hampton Rd. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> DUE TO <u>Ruptured Aneurysmal Aorta</u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs</u> <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>March 6, 1956</u> that I last saw the deceased alive on <u>March 6, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. NW, Wash. D.C.</u>			
ACTUAL SIGNATURE <u>Sidney C. Cousins</u>		PHYSICIAN'S NAME (Type) <u>Sidney C. Cousins- 3921 Ingomar St., N.W.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>9-8-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1 1961

U.S. AIR FORCE

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

2989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>1640 Crittenden St.</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Henry</u> Last <u>Davenport</u> Sr.		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-95</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Star</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel L. Davenport</u>		14. MOTHER'S MAIDEN NAME <u>Helen Duvall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI - Army</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>arteriosclerotic heart disease</u> (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March 14, 1955</u> to <u>March 15, 1955</u> , that I last saw the deceased alive on <u>March 15, 1955</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>Takoma Park 12 Md</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock M.D.</u>		DATE SIGNED <u>Takoma Park 12 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl F. ...</u>		ADDRESS <u>4812 ...</u>	
24a. REC'D BY REGISTRAR <u>3/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

305D

CERTIFICATE OF DEATH

02995

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 110-41-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Red Route 29</u>		d. STREET ADDRESS <u>307 9th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Lance</u> Last <u>Lance</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 2, 1884</u> 71 yrs
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Upper Marlboro, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Lancel</u>		14. MOTHER'S MAIDEN NAME <u>Rose Beall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mrs. William Beall</u> Address <u>Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Hypertensive C.-V. Disease</u> DUE TO <u>Genit. Arteriosclerosis</u> DUE TO <u>Senile Dementia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 yrs</u> <u>18 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>38</u> , to <u>3/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>56</u> , and that death occurred at <u>7</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>305 Prince Georges Lane</u> DATE SIGNED <u>3/23</u>	
PHYSICIAN'S NAME (Type) <u>J. M. Warren</u> <u>Laurel, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/26/56</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Union</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. ...</u> ADDRESS <u>...</u>		24a. REC'D BY REGISTRAR <u>...</u> DATE <u>3-27-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bertina B. Lander</u>

THAU V. C.

APR 4 1956

105-1056

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3051

CERTIFICATE OF DEATH

02926/6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp-</u>		d. STREET ADDRESS <u>2808 Munson St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Edward Davis</u>		4. DATE OF DEATH Month Day Year <u>March 3 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. Water Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Woretta Soper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT Address <u>Wife, Mary Estelle Davis - above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Collagen Disease</u> DUE TO (b) <u>Pericarditis Noctua</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Abscesses Skin Subcutaneous</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Mar 3</u> , 19 <u>56</u> (that I last saw the deceased alive on <u>Mar 3</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John J. Curry</u> M.D. <u>11301 Georgia Ave S.E.</u>		<u>3/3/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 7</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis W. Barber</u> ADDRESS <u>Laytonville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-6-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie S. Thompson</u>	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital. The attending physician and complete this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



A 17

18 8 8

3052

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6014 Melvern Drive				d. STREET ADDRESS 601 Melvern Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LULA L. DAVIS				4. DATE OF DEATH March 25, 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 73 April 25, 1877	
9. AGE (In years and months) 84 82 yrs.		10. IF UNDER 1 YEAR Month 11 Days 05		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME M Benjamin Harper				14. MOTHER'S MAIDEN NAME Mary Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ellise Cooley- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Sclerosis - DUE TO (c) Nephroses, Chronic -				INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage -				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Prince Georges Co., Maryland				20g. (State) Maryland			
21. I certify that I attended the deceased from 9/19/54 , 19____, to 3/25/56 , 19____, that I last saw the deceased alive on 3/24/56 , 19____, and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James A. O'Keefe M.D. 4545 Conn Ave. N.W.				DATE SIGNED 3/25/56			
PHYSICIAN'S NAME (Type) James A. O'Keefe M.D.				4545 Conn Ave. N.W. Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince Georges Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 3-28-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician on.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

217

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Indiana</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Farmington Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MISHAWAKA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Sanitarium</i>		d. STREET ADDRESS <i>620 WEST GROVE STREET</i>	
3. NAME OF DECEASED (Type or print) <i>FRANK XAVIER DeClercq</i>		4. DATE OF DEATH Month <i>3</i> Day <i>1</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-80</i>
9. AGE (In years last birthday) <i>75</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - US Rubber Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Indiana</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>August DeClercq</i>		14. MOTHER'S MAIDEN NAME <i>Actavia Van Huffell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Neice - 10440 Southernland Rd.</i>	
17. INFORMANT <i>Mrs Marion Mahoney</i>		Address <i>10440 Southernland Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>475x Hypoplastic Anemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia Dec 1955</i> DUE TO (c) <i>2 mo. ago</i>		INTERVAL BETWEEN ONSET AND DEATH <i>TWO Months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-20-56, 1956</i> to <i>Mar 1, 1956</i> , that I last saw the deceased alive on <i>Mar 1, 1956</i> , and that death occurred at <i>9:55 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John N. Andrews</i>		ADDRESS (Street, city or town, state) <i>9601 Colesville Rd Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>JOHN N. ANDREWS</i>		DATE SIGNED <i>3-1-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS & BURIAL</i>		22b. DATE THEREOF <i>3/5/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ST. JOSEPHS CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MISHAWAKA, INDIANA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Waverly Humphrey</i>		ADDRESS <i>SILVER SPRING, MARYLAND</i>	
24a. REC'D BY REGISTRAR <i>3-3-56</i>		24b. REGISTRAR'S SIGNATURE <i>John N. Andrews</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1907

RECEIVED

MEDICAL CERTIFICATION

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

3054

CERTIFICATE OF DEATH

03000

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u>			
c. LENGTH OF STAY IN 1b <u>1 Year</u>				d. STREET ADDRESS <u></u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>A</u> Last <u>DORSEY</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>cat</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 18, 1881</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H Riggs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frazier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Matthew Darry Gaithersburg</u> Address <u></u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis without edema</u> DUE TO <u>arteriosclerotic Hypertension</u> DUE TO <u>Cardiorenal Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy Petto Mal</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> 19 <u></u> p. m. <u></u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u></u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 17, 1948</u> , to <u>March 8, 1956</u> , that I last saw the deceased alive on <u>March 7, 1956</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL <u>Webster Sewell</u> M.D.				ADDRESS (Street, city or town, state) <u>Norbeck Rd / Silver Spring</u>			
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>				DATE SIGNED <u>3.9.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Mar 10 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brook Grove Md</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Mar 13 - 56</u>			
24b. REGISTRAR'S SIGNATURE <u>Abraham L. Cooke</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten text, likely a list or notes, appearing in the upper middle section of the page.

Handwritten text, possibly a title or a specific entry, located in the center of the page.

Handwritten text, appearing in the lower middle section of the page.

Handwritten text, appearing in the bottom section of the page, possibly a signature or a concluding note.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and complete certificate has been signed by the attending physician and complete certificate has been signed by the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate has been signed by the attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3055

CERTIFICATE OF DEATH

03001

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory Grove Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lo</u> Middle <u>Kerne</u> Last <u>Elizabeth Duwall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1941</u>
9. AGE (In years last birthday) <u>14</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alfred Duwall</u>	
14. MOTHER'S MAIDEN NAME <u>Eleanor Neal</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Eleanor Neal</u> Address <u>Gaithersburg, Md. Route # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaphylaxis</u> DUE TO <u>Penicillin & Streptomycin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral Pneumonia</u> (c) <u>1 day</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 8, 1954</u> to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>6 A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u>		ADDRESS (Street, city or town, state) <u>Norbeck Rd, Silver Spring</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		DATE SIGNED <u>3/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shuman</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>Mar 27/56</u>		24b. REGISTRAR'S SIGNATURE <u>Whitman L. Carter</u>	

BUREAU V. P.

1956

100

2991

CERTIFICATE OF DEATH

Reg. Dist. No.

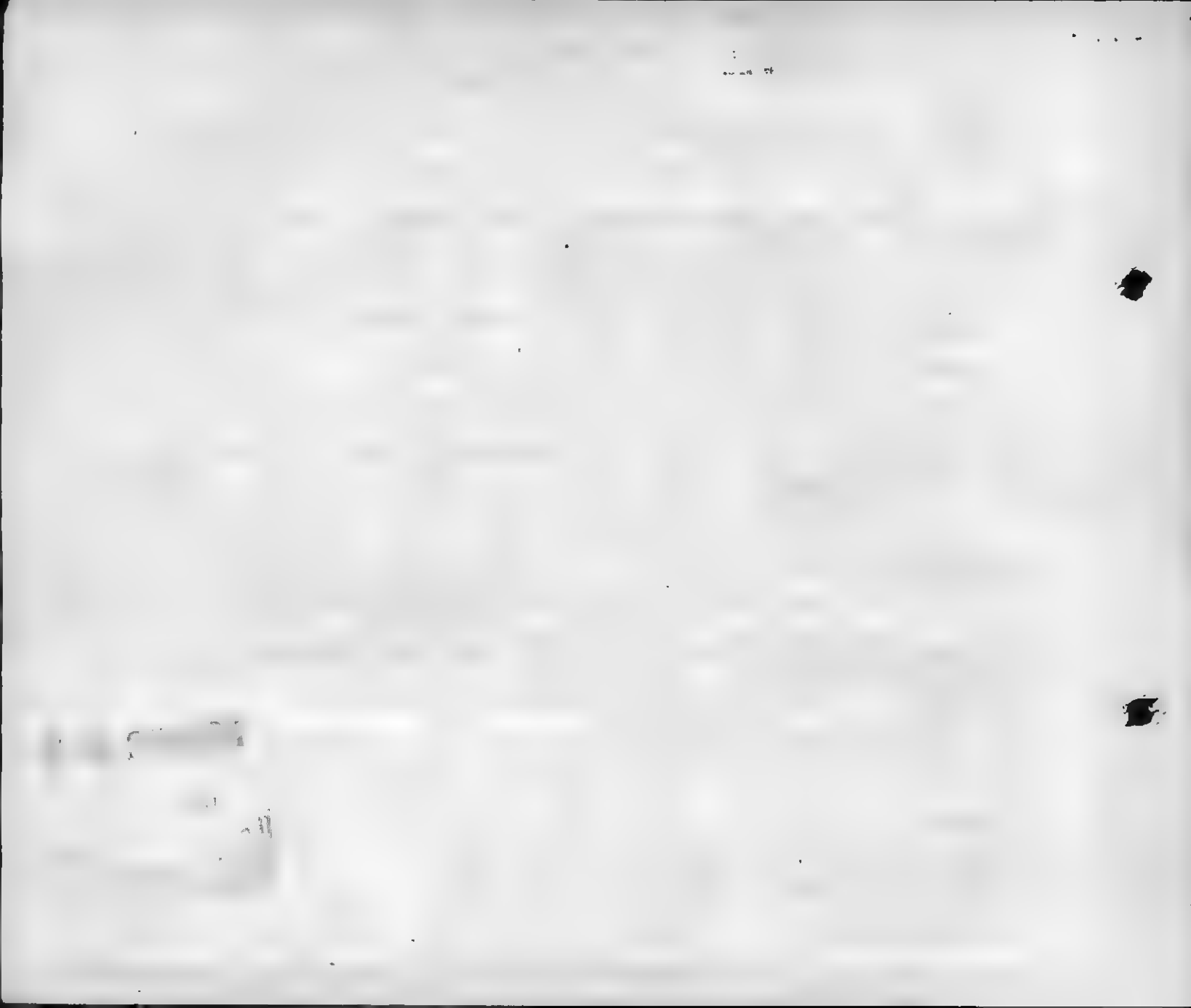
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 hr-10 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>8914 Walden Rd</u>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> <u>L.</u> <u>Dyer</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-08</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GREENE & DYER, INC.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram H. Dyer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Staley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>@ 8 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>54</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-18-</u> , 19 <u>56</u> , and that death occurred at <u>2:25 A.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		ADDRESS (Street, city or town, state) <u>9620 Old Bladensburg Rd</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		DATE SIGNED <u>3/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, aw. SS. Md</u>		ADDRESS <u>8434 Ga.</u>	
24a. REC'D BY REGISTRAR <u>3/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. B. B. B.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2992

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington General Hospital		d. STREET ADDRESS 1211 11th St. N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last William Henry		4. DATE OF DEATH Month Day Year March 5 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/1911
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Reserve		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME James W. Dyer		14. MOTHER'S MAIDEN NAME Laura A. Ziegler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 53-0070-157	
17. INFORMANT Mrs. L. A. Dyer, 1211 11th St. N.W., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease (c) Atherosclerosis Aneurysm		INTERVAL BETWEEN ONSET AND DEATH 12 hours 10 yrs 11 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1956, to March 1956, that I last saw the deceased alive on March 1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Dyer		DATE SIGNED March 5 1956	
PHYSICIAN'S NAME (Type) J. H. Dyer		M.D. J. H. Dyer	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/27/56	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRICE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		ADDRESS 8434 4th St. S.W.	
24a. REC'D BY REGISTRAR DATE 3/27/56		24b. REGISTRAR'S SIGNATURE J. H. Dyer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

1000

100

100

3056

CERTIFICATE OF DEATH

03004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural-Rockville, Md. (Manor Club)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN WILLIAM EBERT</u>		4. DATE OF DEATH <u>March 10, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mch 22, 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR <u>11</u> Months <u>18</u> Days	11. IF UNDER 24 HRS <u>11</u> Hours <u>18</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Ebert</u>		14. MOTHER'S MAIDEN NAME <u>Emma E. Stanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Jerney Ebert-Item# 2</u>	
17. INFORMANT <u>Jerney Ebert-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>56</u> , and that death occurred at <u>1:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Bonifant</u> M.D.		ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>D. Bonifant</u>		DATE SIGNED <u>3/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Etchison</u> ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>3/12/56</u>	24b. REGISTRAR'S SIGNATURE <u>Lawell H. Bryant</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MR. J. C.

1870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completed in by the funeral director. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03005

3057

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 YRS.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,602 IDLEWOOD ROAD				d. STREET ADDRESS 11,602 IDLEWOOD ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROSA Middle BELLE Last EDWARDS				4. DATE OF DEATH Month MARCH Day 15 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1873	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY EDWARDS				14. MOTHER'S MAIDEN NAME SARAH unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MR. RANDOLPH C. EDWARDS, 11602 IDLEWOOD ROAD SILVER SPRING, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Secondary Anemia DUE TO (c) Cancer of Cecum							INTERVAL BETWEEN ONSET AND DEATH 2 mos. 14 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Chronic Glomerulonephritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1, 1954 to March 15, 1956 , that I last saw the deceased alive on Feb. 28, 1956 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell B. Arnold		M.D. 8801 Coleville Road		ADDRESS (Street, city or town, state)		DATE SIGNED March 15, 1956	
PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		Silver Spring, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/17/56		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/16/56	
				24b. REGISTRAR'S SIGNATURE Francis J. Potter			

BUREAU V. S.

MAR 10 1930

RECEIVED

3058

CERTIFICATE OF DEATH

03006

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>2601 Arvin Street</u>	
3. NAME OF DECEASED (Type or print) <u>Alexander John Eisenrauch</u>		4. DATE OF DEATH <u>March 28 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woodworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoreham Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolph Eisenrauch</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-2419</u>	
17. INFORMANT <u>Wife, Louise Eisenrauch above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Iliaic thrombosis</u> DUE TO (c) <u>Suprapubic prostatectomy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>2-3 d.</u> <u>8 ✓</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18, 1956</u> , to <u>3/28, 1956</u> , that I last saw the deceased alive on <u>3/27, 1956</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhoe</u>		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhoe</u>		DATE SIGNED <u>3/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>2-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate shall be filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 11 1964
U.S. AIR FORCE

3059

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4325 East West Highway</u>	
3. NAME OF DECEASED (Type or print) <u>William J. Ellison</u> First Middle Last		4. DATE OF DEATH <u>March 29</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-97</u>
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR <u>0</u> Months <u>27</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Ellison</u>		14. MOTHER'S MAIDEN NAME <u>N. Judd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>579-18-8894</u>	
17. INFORMANT <u>Constance M Ellison</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary insufficiency</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 29</u> , 19 <u>56</u> to <u>March 29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>March 29</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Cherry Chase Dr</u> DATE SIGNED <u>3/29/56</u> ACTUAL SIGNATURE <u>George A. Gray Jr</u> M.D. <u>Cherry Chase, Md</u> PHYSICIAN'S NAME (Type) <u>George A. Gray Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-2-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	22d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>4-2-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 4 1950

BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3060

CERTIFICATE OF DEATH

03008

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5206 Chandler Road				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5206 Chandler Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARNOLD C. ENGEL, SR.				4. DATE OF DEATH March 30, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-13-1890	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 4 Days 0 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Acct.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. A. Engel				14. MOTHER'S MAIDEN NAME Catherine Scherite			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO. yes		17. INFORMANT Arnold C. Engel, Jr. - Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Coronary Arterial Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Heart Disease (c) Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 7 hrs. 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Mar, 1953 to 30 Mar, 1956 , that I last saw the deceased alive on 25 Mar, 1956 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED 30 Mar 56							
ACTUAL SIGNATURE Warren Burch M.D.							
PHYSICIAN'S NAME (Type) Warren Burch				ADDRESS 4220 - 45th. St., N. W. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md.		24a. REC'D BY REGISTRAR 4-2-56	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

RECEIVED

APR 4 1956

BUREAU V. S.

3061

CERTIFICATE OF DEATH

03009

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Oak Street				e. STREET ADDRESS 10 Oak Street			
3. NAME OF DECEASED (Type or print) First Annie Middle Laura Last Fairall				4. DATE OF DEATH Month March Day 21 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1868		9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months 8 Days 10	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. F. Fairall				14. MOTHER'S MAIDEN NAME E. Woods			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Merton F. Duvall Address 10 Oak St. Gaith. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 12 1956 to March 21 1956 , that I last saw the deceased alive on 3/17 , 19 56 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Luciano I. Leal				ADDRESS (Street, city or town, state) 112 N Frederick Ave.			
PHYSICIAN'S NAME (Type) Luciano I. Leal				DATE SIGNED Gaithersburg Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-56		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE Mar 22 56	
				24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and the funeral director, after the death certificate has been signed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 4 1964

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03010

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda R-3		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda R-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Falls Rd.				d. STREET ADDRESS Falls Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Wilbert Fairfax <div style="text-align: center; font-size: small;">First Middle Last</div>				4. DATE OF DEATH March 24 19 56 <div style="text-align: center; font-size: small;">Month Day Year</div>			
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1902		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY cement finisher		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fairfax				14. MOTHER'S MAIDEN NAME Julia Gamby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Velvet Fairfax, Bethesda, Md. <div style="text-align: center; font-size: small;">Address</div>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous attacks						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/25/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn,		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Lunden</i>				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 2-29-56 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

3063

1. PLACE OF DEATH- COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2401 Pine Ave</u>		STREET ADDRESS (If rural, give location) <u>8507 Old Bladensburg Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Samuel</u> (Middle) <u>Fort</u> (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar</u> <u>5</u> <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-15-87</u>
9. AGE last birthday <u>69</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nut Vendor</u>	
11. BIRTHPLACE (State or foreign country) <u>Prussia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna Fort (wife) Same address</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422 Immediate cause (a) <u>Coronary occlusion</u>		<u>sudden</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 7, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>King David Memorial Cemetery, Falls Church, Virginia</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>3-5-56</u>	REGISTRAR'S SIGNATURE <u>James Teller</u>	24. FUNERAL DIRECTOR <u>W. H. Langford</u>	ADDRESS <u>Washington, D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR

RECEIVED
MAR 10 1950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03012

Reg. Dist.

No. 212

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>201 Lee St</u>		<u>3 yrs</u>		TOWN <u>Gaithersburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gaithersburg</u>				STREET ADDRESS (If rural, give location) <u>201 Lee St</u>			
3. NAME OF DECEASED: (First) <u>Brosch</u>		(Middle) <u>Grace</u>		(Last) <u>Franklin</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept 9-1926</u>	9. AGE last birthday: <u>29</u> yrs	IF UNDER 1 YEAR: Months <u>6</u> Days <u>8</u>		IF UNDER 24 HRS: Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Wilbert Mattoon</u>				14. MOTHER'S MAIDEN NAME: <u>Carolee Roseman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>201 Lee St - Kenneth S. Franklin Gaithersburg</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>3533</u>		(a) <u>Asphyxia due to laryngeal spasm</u>				<u>several</u>	
Antecedent cause(s)		(b) <u>aspiration of blood due to laceration of tongue</u>				<u>dark in bed on floor</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>fall following epileptic seizure</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>encephalitis several yrs ago</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosch</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>3-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		LOCATION (City, town, or county) (State) <u>Gaithersburg</u> <u>md</u>	
DATE REC'D BY LOCAL REG. <u>Mar 13, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

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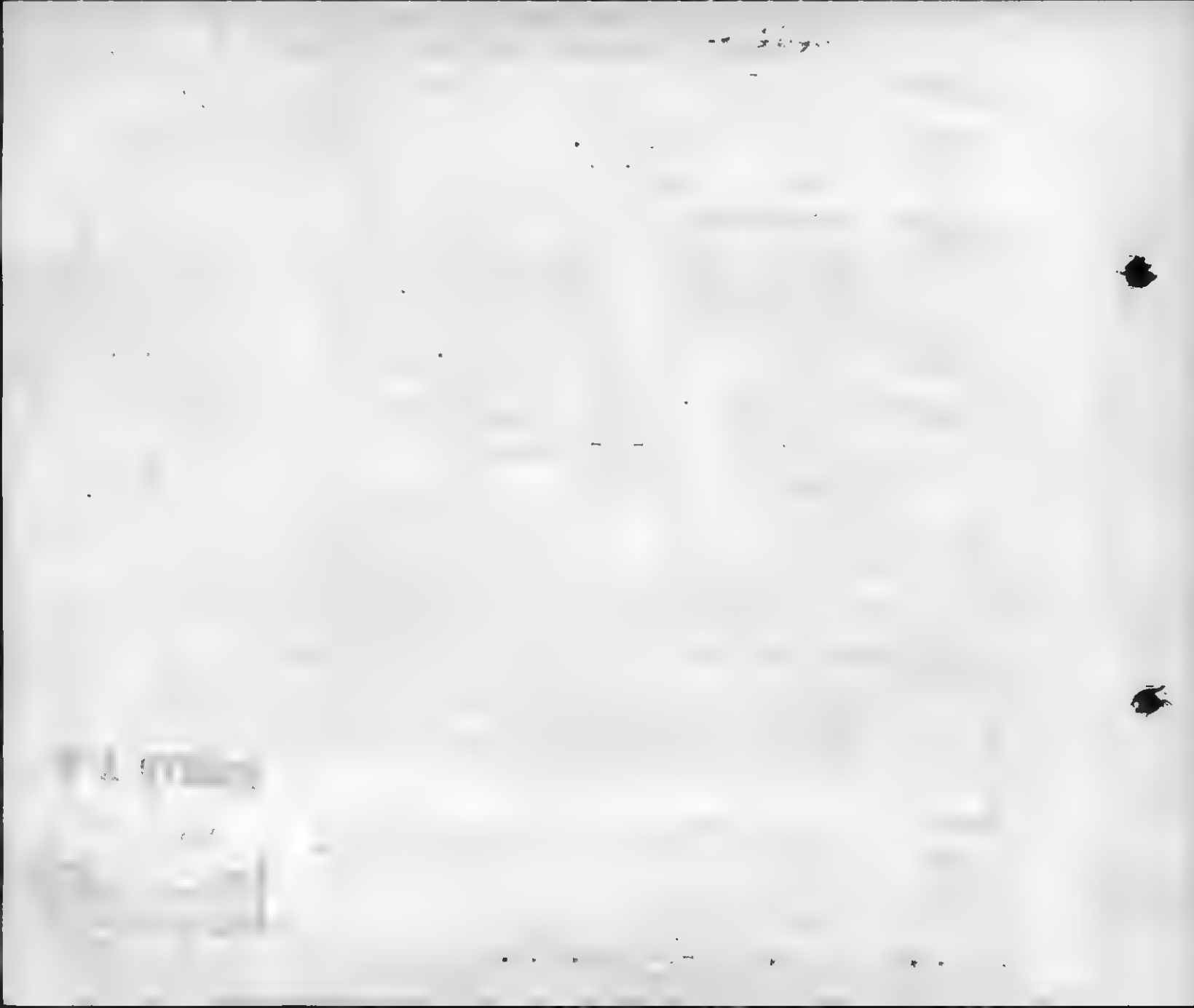
MARYLAND STATE EXAMINER'S CERTIFICATE OF DEATH

2993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13013**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> c. LENGTH OF STAY IN TB <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>L. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-15-2 d. STREET ADDRESS <u>1703 Crosby road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Melville</u> <u>Frank</u> <u>Freas, Jr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1956</u>																			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1917</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Comm.</u>				11. BIRTHPLACE (State or foreign country) <u>Conn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>J. S. A.</u>											
13. FATHER'S NAME <u>Melville Frank Freas, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>May Shaw</u>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>March '42-'45</u> <u>202-01-9875</u>				17. INFORMANT <u>Father</u>				Address <u> </u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>2</u> hr.											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED									
EXAMINER'S NAME (Type) <u>Frank J Broschart</u>												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 31, 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>4/1/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901-14th st. N.W.</u>												24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE <u>4/3/56</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3065

CERTIFICATE OF DEATH

Reg. Dist. No. 03014 274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>5930-13th Place N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last <u>FRIEDMAN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>11th</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Painter)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House painter</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Harry Friedman</u>				14. MOTHER'S MAIDEN NAME <u>Zlota Lipson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sam Jeweler</u> Address <u>Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (CVA)</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>over 1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February, 1955</u> , to <u>March 10, 1956</u> , that I last saw the deceased alive on <u>March 10th, 1956</u> , and that death occurred at <u>3:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Dove</u> M.D. <u>1801 Eye St. N.W.</u>				ADDRESS (Street, city or town, state) <u>Washington 6 D.C.</u> DATE SIGNED <u>3/11/56</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL DOVE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 13, 1956</u>		<u>MT. Hope Cemetery</u>		<u>Maspeth, L.I.N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Haysauster, Secy</u>				ADDRESS <u>3501-14 St NW</u>		24a. REC'D BY REGISTRAR DATE <u>12 10 56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Frances Poth</u>			

10-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital's attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2994

03015

CERTIFICATE OF DEATH

Item: C, File: 3193 3-1-56 et

Reg. Dist. No. 22.3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Saint Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Saint Hosp.</u>		d. STREET ADDRESS <u>Takoma Park Md</u>	
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>O</u> Last <u>Futrowsky</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-03</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry cleaning Bus</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>Europe-Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Isaac Futrowsky</u>		14. MOTHER'S MAIDEN NAME <u>Lemkovitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>5-78-03-2029</u>	
17. INFORMANT <u>Washington Saint Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage - 48 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 29, 1956</u> to <u>March 4, 1956</u> (that I last saw the deceased alive on <u>3-4-56</u> 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Tal Faneit</u> M.D. <u>6727-16th St. N.E.</u>			
PHYSICIAN'S NAME (Type) <u>TAL FANEIT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wheatland</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis & Son</u>		ADDRESS <u>Wash DC</u>	
24a. REC'D BY REGISTRAR <u>F. Wilson</u>		24b. REGISTRAR'S SIGNATURE <u>Redd</u>	
DATE <u>3-6-56</u>			

U. S. A.

1897

1895

03016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - 3.3.3. Md.</u>		c. LENGTH OF STAY IN 1b <u>5 yrs. 5 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium and Hospital</u>		d. STREET ADDRESS <u>5210 Nahant Street</u>	
e. IS RES. DECEASED ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Minnie</u> <u>Lawrence</u> <u>Gardiner</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 22, 1880</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Gainger Field Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta La Forge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>215-05-8509D Lawrence Gardiner Blauvelt NY.</u>		16. SOCIAL SECURITY NO. <u>215-05-8509D</u>	
17. INFORMANT <u>Blauvelt NY.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac coronary Occlusion</u> DUE TO <u>Cachexia due to cerebral arterio-sclerosis</u> (b) <u>with psychosis</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>54</u> , to <u>March 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>6:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abner J. Kistler</u> M.D.		ADDRESS (Street, city or town, state) <u>Cedar Croft Sanitarium Silver Spring Md.</u>	
DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>A. J. Kistler, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 2 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EMMANUEL CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>Glencoe Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Jenkins & Sons Co</u>		ADDRESS <u>4905 YORK Rd</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Francis Patten</u>	
DATE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 should be filed in by the funeral director. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3067

CERTIFICATE OF DEATH

03017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 33 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 31 Paul Road	
3. NAME OF DECEASED (Type or print) First Virginia Middle Norine Last Gardner		4. DATE OF DEATH Month March Day 6 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1927
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Burgess		14. MOTHER'S MAIDEN NAME Mildred Watt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 539-18-2100	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema and congestive cardiac failure DUE TO Adrenal cortical carcinoma metastatic to liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) lungs and spine DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 2, 1956 to March 6, 1956 , that I last saw the deceased alive on March 6, 1956 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center, NIH, Bethesda, Md. 3/7/56			
ACTUAL SIGNATURE Herbert Lubs		M.D. The Clinical Center, NIH, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Herbert Lubs, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3-7-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Freemont		22d. LOCATION (City, town, or county) (State) Stuben Co., New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-8-56	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3068 CERTIFICATE OF DEATH

03018

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE DIST. OF COLUMBIA COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 2701 14th St., N.W. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Gertrude Middle Ann Last GEARY			4. DATE OF DEATH Month March Day 20 Year 19 56								
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH 1 October 1878		9. AGE (In years, last birthday) 77 7/8 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min
IF UNDER 1 YEAR	IF UNDER 24 HRS										
Months	Days										
	Hours										
	Min										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) New York							
12. CITIZEN OF WHAT COUNTRY? U.S.											
13. FATHER'S NAME Charles A. CLISHAM			14. MOTHER'S MAIDEN NAME Mary Ann FARMER								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No unknown		17. INFORMANT Address Arlington, Va. (Son) Daniel J. GEARY, Resident 1758 N. Troy St.,									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary atherosclerosis (c) Generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH minutes ↓ ↓						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 Feb. 19 56 to 20 March 19 56 that I last saw the deceased alive on 20 March 19 56 and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-20-56											
ACTUAL SIGNATURE <i>L. Schlang</i> M.D.											
PHYSICIAN'S NAME (Type) H. A. SCHLANG, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 23 Mar 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery							
22d. LOCATION (City, town, or county) Arlington, Virginia (State)											
23. FUNERAL DIRECTOR'S SIGNATURE W.L. Farrar Address Hines Funeral Home 2901 14th St N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 3-20-56 24b. REGISTRAR'S SIGNATURE <i>Mary E. Connelly</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 96 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and complete certificate has been signed by the attending physician. After this certificate has been signed by the attending physician and complete certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

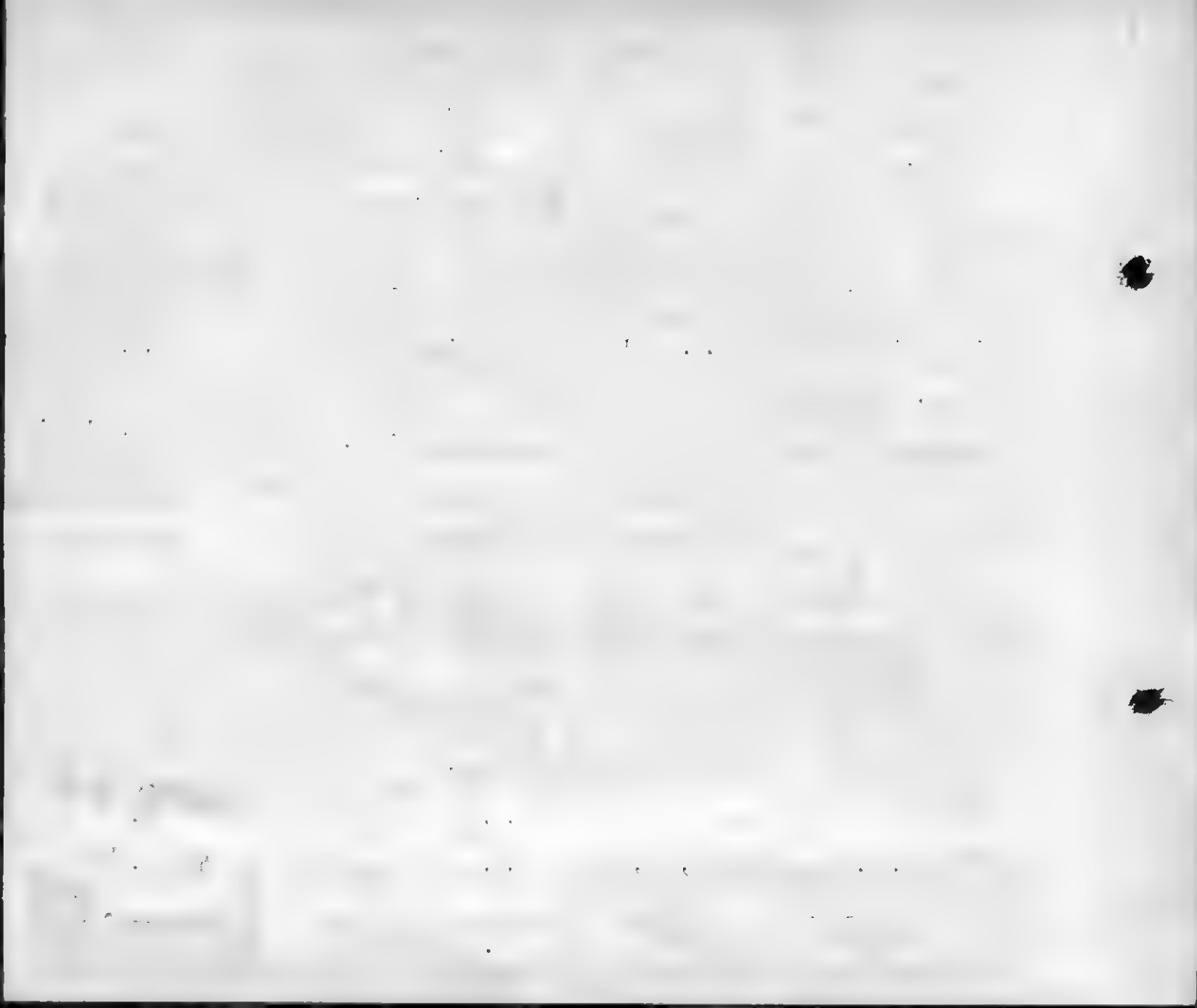
3069

CERTIFICATE OF DEATH

03019

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ...	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, - (Rural)		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		d. STREET ADDRESS 24 "H", Riverside Village	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAE Middle EIDSON Last GILBERT		4. DATE OF DEATH Month March Day 20 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 October 1919
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months ... Days ... Hours ... Min ...	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter M. COLLINS		14. MOTHER'S MAIDEN NAME Lilly Mae Eidson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Wendlin G. GILBERT, 24 "H" Riverside Village, Indian Head, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis DUE TO Lacunar's cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ... (c) ... PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Disorders, psychotic due to physical etiology (toxic delirium)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ...	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) ...		(County) ... (State) ...	
21. I certify that I attended the deceased from 14 March , 19 56 , to 20 March , 19 56 , that I last saw the deceased alive on 20 March , 19 56 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ... DATE SIGNED ...			
ACTUAL SIGNATURE McAllison, Jr.		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) M. E. ALLISON JR LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-56	22c. NAME OF CEMETERY OR CREMATORY Old Dorham Episcopal Cemetery Ironside, Maryland	22d. LOCATION (City, town, or county) (State) ...
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, La Plata, Md.		24a. REC'D BY REGISTRAR 3-21-56	
24b. REGISTRAR'S SIGNATURE Barry E. Parrelly			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3070

CERTIFICATE OF DEATH

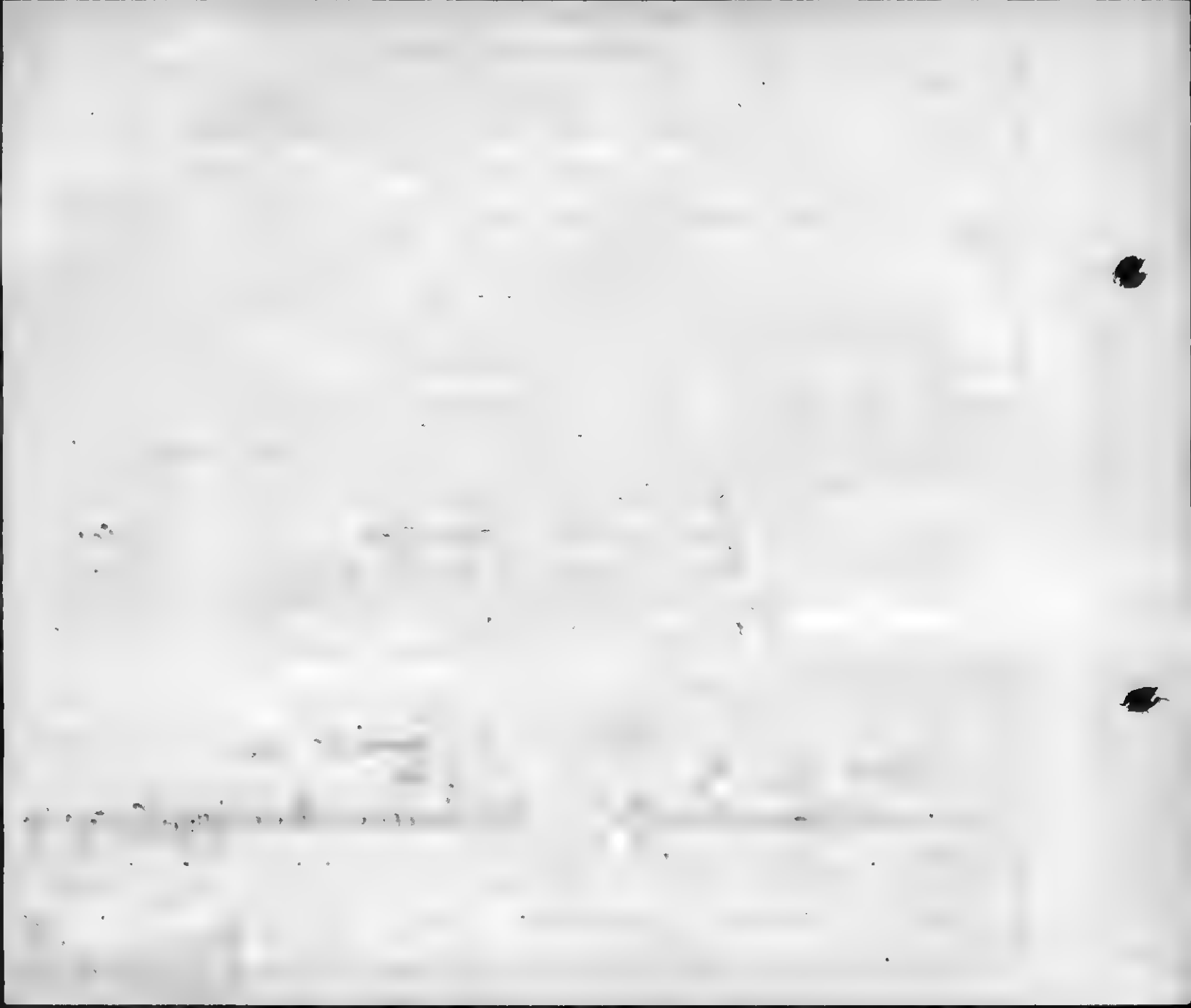
Reg. Dist. No. 216

03020

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8110 Georgetown Road		d. STREET ADDRESS 8110 Georgetown Road	
3 NAME OF DECEASED (Type or print) First JESS Middle SPANGLER Last GILL		4. DATE OF DEATH Month March Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1880
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Spangler	
14. MOTHER'S MAIDEN NAME Sarah Elizabeth Rebuck		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO. 577-01-6946		17. INFORMANT Mrs. Ruth A. Gill Berger-Daughter Address Bethesda, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 18 hours 4 years 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive ileus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1952 to March 20, 1956 , that I last saw the deceased alive on March 20, 1956 , and that death occurred at 8:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Roger Kurtz M.D.		ADDRESS (Street, city or town, state) 3701 Connecticut Ave. N.W. Wash. D.C. DATE SIGNED 3-20-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-1956	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cem.
22d. LOCATION (City, town, or county) Washington		(State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 3-21-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completed by the funeral director. After this certificate is signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 216

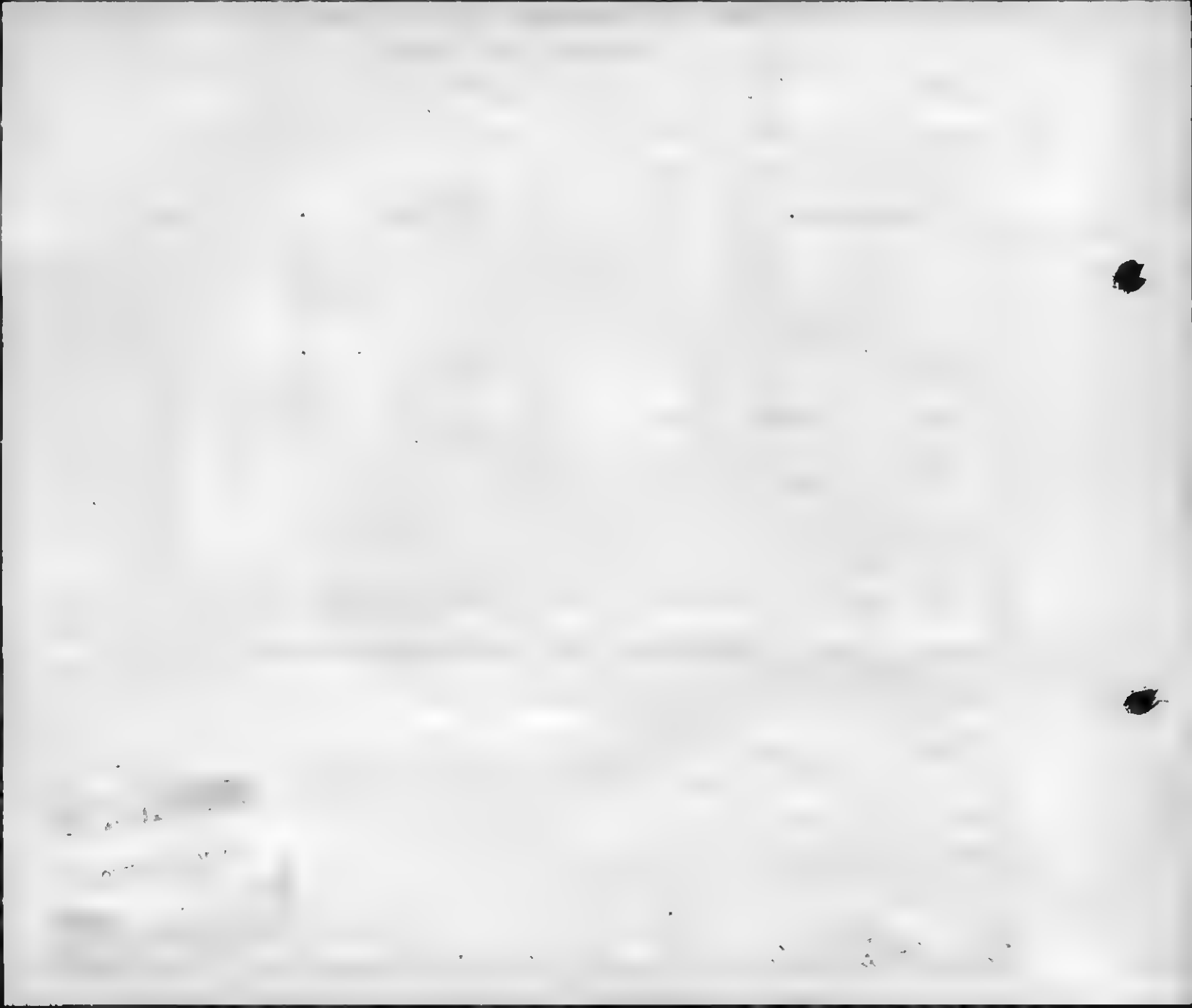
3071

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7807 Exeter Rd.</u>		d. STREET ADDRESS <u>7807 Exeter Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eustace Straughn Glascock</u>		4. DATE OF DEATH Month Day Year <u>March 13, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/63</u>
9. AGE (In years last birthday) <u>92</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired patent attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gloucester, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>Gloucester, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Luther Glascock</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Maria</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth G. Taylor</u>		Address <u>daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemiplegia, left, acute</u> <u>3311X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalised</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs.</u> <u>5 yrs +</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1954</u> to <u>March 13, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3921 Ingomar St. NW, Wash DC 3.13.56</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets Church Cem. Annapolis, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. M. Jones Co.</u>		ADDRESS <u>2901 14th St. N.W.</u>	24a. REC'D BY REGISTRAR DATE <u>8-14-56</u>
		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03022

3072

CERTIFICATE OF DEATH

Reg. Dist. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Dist. Of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitorium				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
f. STREET ADDRESS 1210- Mass. Ave. N.W.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle H. Last GOODE				4. DATE OF DEATH Month March Day 11 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1880		9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 1 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Cashier		10b. KIND OF BUSINESS OR INDUSTRY Auto Parking Bus.		11. BIRTHPLACE (State or foreign country) Cleveland County, No. Caro.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius M. Goode				14. MOTHER'S MAIDEN NAME Laura Frances Warlick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Elmer Shane, Sis.- 1210- Mass. Ave. N.W., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Rectum with metastases DUE TO metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Jan. 1956 to 8 March 56 , that I last saw the deceased alive on 8 March 1956 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert C. Haile M.D. 35 New York Ave. N.W.				DATE SIGNED 11 March 56			
PHYSICIAN'S NAME (Type) Robert C. Haile, M.D., 35- New York Ave. N.W., Washington, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 13/56		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.				ADDRESS 1300-N. ST. N.W. D.C.		24a. REC'D BY REGISTRAR DATE 3/15/56	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3073

CERTIFICATE OF DEATH

03023

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Louisiana b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baton Rouge	
f. STREET ADDRESS 1109 Daniel Webster		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle James Last Green, Jr.		4. DATE OF DEATH Month March Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1953
9. AGE (In years last birthday) yrs 2		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren Green		14. MOTHER'S MAIDEN NAME Frances Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 year
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 18, 1956 , to March 8, 1956 , that I last saw the deceased alive on March 8, 1956 , and that death occurred at 5:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Claude E. Forkner, Jr. M.D.		ADDRESS (Street, city or town, state) The Clinical Center, NIH, Bethesda, Md. DATE SIGNED 3/8/56	
PHYSICIAN'S NAME (Type) Claude E. Forkner, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-10-56	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Frazier Funeral Home		24a. REC'D BY REGISTRAR DATE 3-9-56	
ADDRESS 389 R.I. Ave. N.W.		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

WILSON A. J.

1911

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 193024

3074 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> - MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> - <u>8-8-54</u>	STATE <u>MD.</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> -
X TOWN <u>Olney</u>	HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hospital</u>	STREET ADDRESS (If rural, give location) <u>Sharon Chronic Hospital</u>	
3. NAME OF DECEASED: (Type or Print) <u>Julia A. Hardesty</u>		4. DATE OF DEATH: <u>March 13</u> 19 <u>56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Sept. 29, 1867</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. <u>88</u> yrs Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Washington - D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas M. Harrey</u>		14. MOTHER'S MAIDEN NAME: <u>Julia H. Adams -</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
16. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS: <u>Mrs. William Amos, Spencerville Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Femoral artery occlusion (left)</u>		3 day	
ANTECEDENT CAUSE (S) (B) <u>Ren. art. Sclerosis - Diabetes</u>		10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Myelitis acute</u>		20 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH, (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 8</u> , 19 <u>54</u> to <u>3-13</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10 March</u> , 19 <u>56</u> , and that death occurred at <u>7:10 P</u> M. from the causes and on the date stated above.			
SIGNATURE <u>John Wesley Ziegler</u> M.D.		DATE SIGNED <u>March 16, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-56</u>		REGISTERAR'S SIGNATURE <u>Gertrude B. Lawler</u>	
24. FUNERAL DIRECTOR <u>Wm. W. Park</u>		ADDRESS <u>Spencerville Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3075

03025

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 714

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING		LENGTH OF STAY (in this place) Since 1947		CITY (If outside corporate limits write RURAL and give nearest town) SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8317 DRAPER LANE				STREET ADDRESS (If rural, give location) 8317 DRAPER LANE			
3. NAME OF DECEASED: (First) Lewis (Middle) S (Last) Hart				4. DATE OF DEATH (Month) Mar (Day) 20 (Year) 1956			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE	8. DATE OF BIRTH: 7/24/88	9. AGE last birthday: 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Clerical				10b. KIND OF BUSINESS OR INDUSTRY: Wash. Gas Light Co.		11. BIRTHPLACE (State or foreign country): Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: WILLIAM F. HART			
14. MOTHER'S MAIDEN NAME: HELEN A. STEPHENS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: 577-07-7548				17. INFORMANT & ADDRESS: Mrs. Leonard J. Leland, 3101 18th St., N.W. Washington, D. C.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Coronary Occlusion							Sudden
DUE TO							
Antecedent cause(s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <i>Frank B. Borchert</i>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED 3-20-56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 3/23/56		NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		LOCATION (City, town, or county) (State) Washington, D. C.	
DATE REC'D BY LOCAL REG. 3-24-56		REGISTRAR'S SIGNATURE <i>Francis C. Toller</i>		24. FUNERAL DIRECTOR <i>Walter C. Humphrey</i>		ADDRESS Silver Spring, Md.	

17/1/1904

3019

CERTIFICATE OF DEATH

03026

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution- Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 240 N. Washington Street.,				d. STREET ADDRESS 240 N. Washington Street.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last Margaret Elizabeth Hartman		4. DATE OF DEATH Month Day Year March 26, 1956			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1892		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Charwoman		10b. KIND OF BUSINESS OR INDUSTRY Court House		11. BIRTHPLACE (State or foreign country) Rockville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Wesley Carroll				14. MOTHER'S MAIDEN NAME Margaret Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret A. Browne. Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C. R. Disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1949 to March 26, 1956 , that I last saw the deceased alive on March 25, 1956 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Webster Sewell M.D. Rockville, Md. March 31, 1956							
ACTUAL SIGNATURE WEBSTER SEWELL, M.D.		PHYSICIAN'S NAME (Type) WEBSTER SEWELL, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/56		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. K. ...				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 4/2/56	
				24b. REGISTRAR'S SIGNATURE Sewell St. / ...			

FD-302 (Rev. 11-27-60)

100-3-1005

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03027

3976

CERTIFICATE OF DEATH

Reg. Dist. No. 214

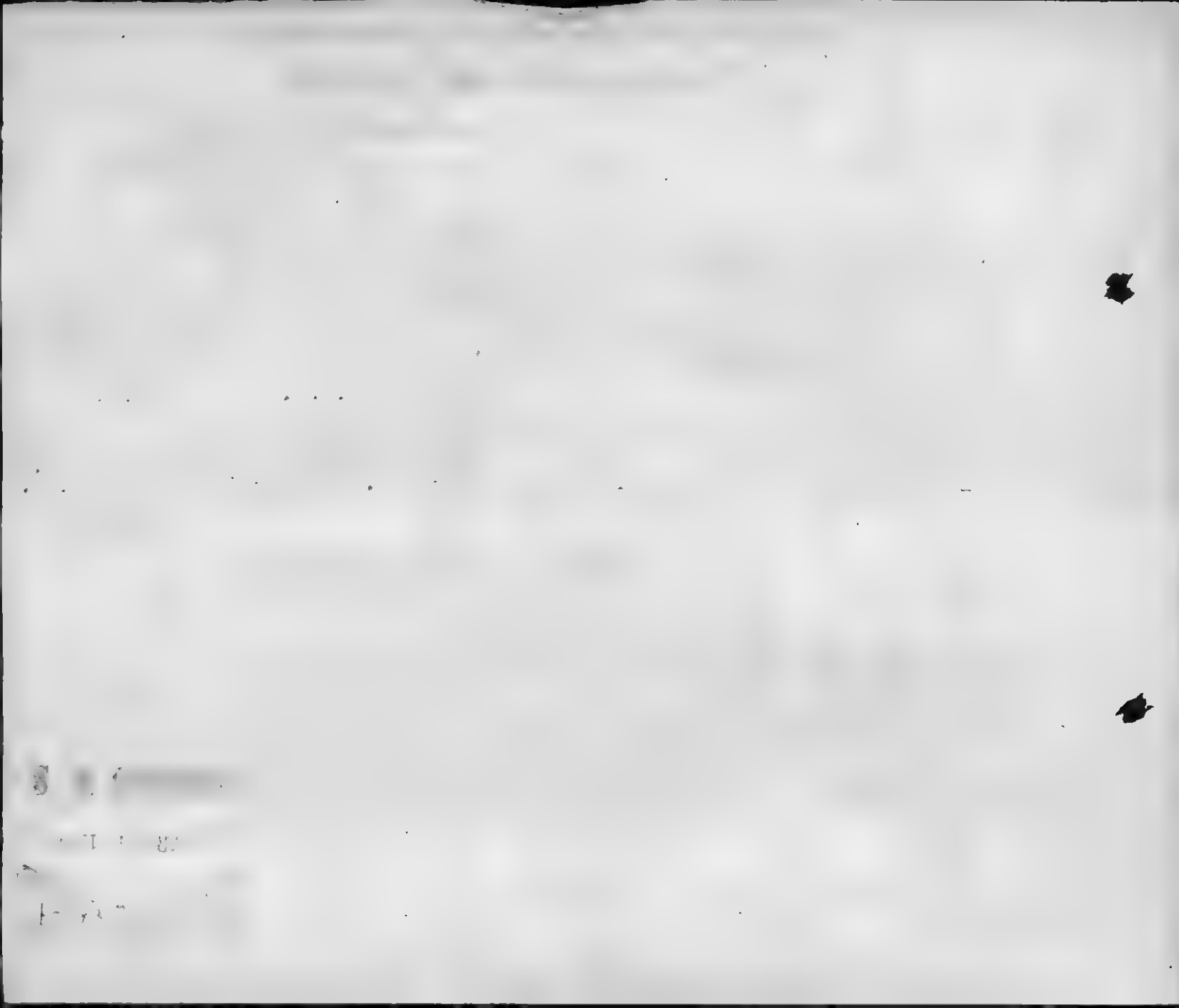
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1608 Moffet Road</u>				STREET ADDRESS (If rural give location) <u>1608 Moffet Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY FRANCES HARTUNG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3-17-56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>July 23, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Coberth</u>				14. MOTHER'S MAIDEN NAME <u>Unobtainable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>1608 Moffett Rd. Harry B. Hartung-Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>24 HRS</u>			
4431 IMMEDIATE CAUSE (A) <u>ACUTE CONGESTIVE CARDIAC FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSION</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-21-1955</u> to <u>3-17-1956</u> , that I last saw the deceased alive on <u>3-16-1956</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leo J. Schildhaus</u>				DATE SIGNED <u>3/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/20/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Frances Potter</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Wines Company</u>		ADDRESS	
DATE <u>3-19-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3077

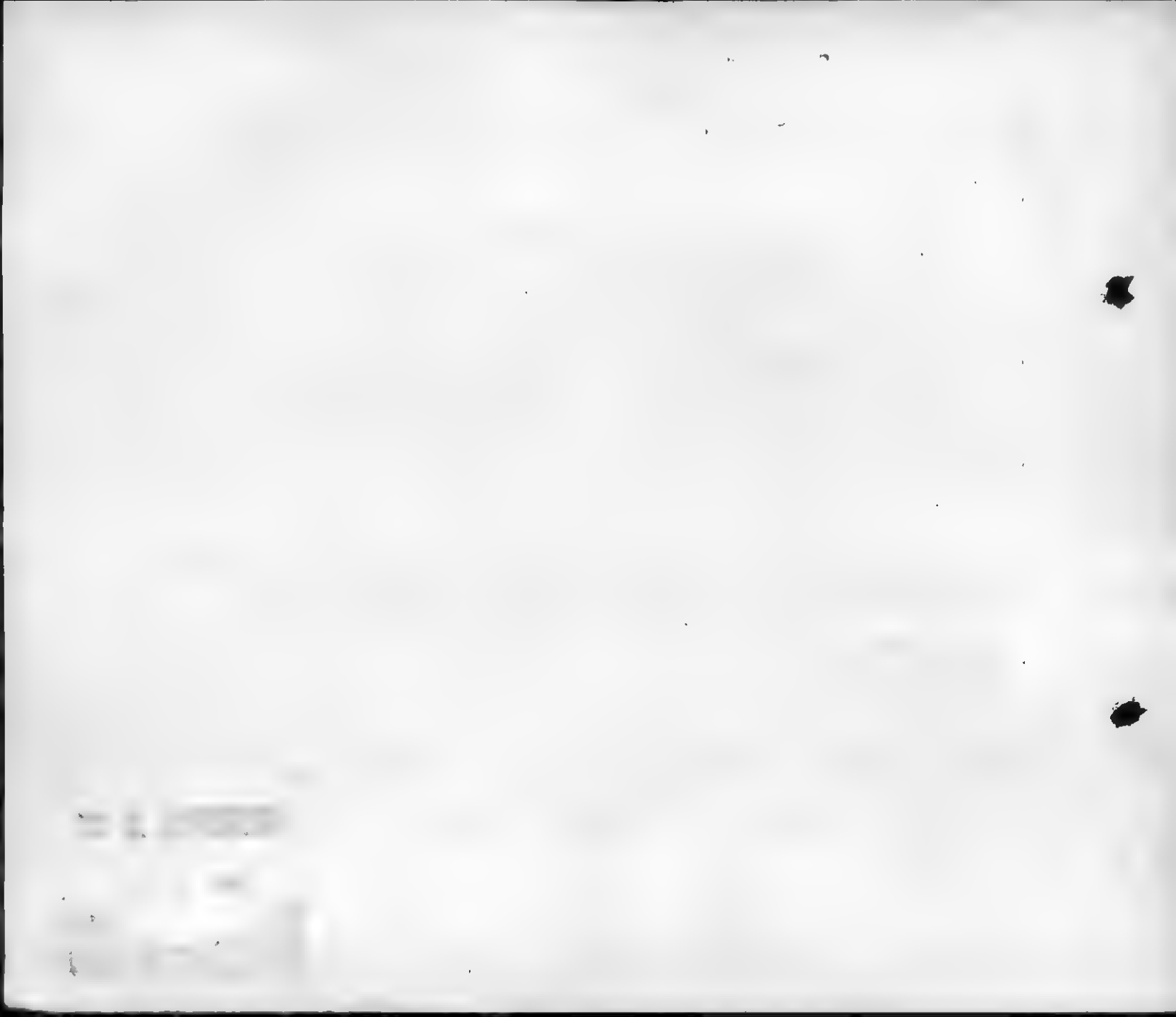
CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SILVER SPRING</u>		<u>Feb. 1, 1952</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Lane Nursing Home</u>				STREET ADDRESS (If rural give location) <u>9810 Georgia Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>MARY</u>		(Middle) <u>E</u>		(Last) <u>HEIL</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>March 11, 1879</u>	
				9. AGE last birthday: <u>76</u> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife - Own home</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Robert Montgomery</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Mac Laney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Thomas M. Jenkins, 8708 Susanna Lane North Chevy Chase, Md.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>HYPERTENSIVE HEART DISEASE</u>							
ANTECEDENT CAUSE (B) <u>ESSENTIAL HYPERTENSION</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>GENERALIZED ARTERIO SCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>SENILITY</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-1</u> 19 <u>52</u> to <u>3-4</u> 19 <u>56</u> that I last saw the deceased alive on <u>3-4</u> 19 <u>56</u> and that death occurred at <u>9:20 p.m.</u> M, from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Frances Tatter</u>		FUNERAL DIRECTOR <u>Warner L. Pumphrey</u>		ADDRESS <u>8434 GA. RD. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3078

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 94 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health				d. STREET ADDRESS 3543 Hertford Place, N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last Myer (None) Herman				4. DATE OF DEATH Month Day Year March 10, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1885	9. AGE (In years last birthday) yrs 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Russia		
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Myer Herman			
14. MOTHER'S MAIDEN NAME Miriam Slotnikov				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Address The medical record, The Clinical Center			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, primary bronchogenic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 7, 1955 , to March 10, 1956 , that I last saw the deceased alive on March 10, 1956 , and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Lester M. Cramer, M.D.				DATE SIGNED 3/10/56			
ACTUAL SIGNATURE Lester M. Cramer, M.D.				PHYSICIAN'S NAME (Type) Lester M. Cramer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF Mar 11/56		22c. NAME OF CEMETERY OR CREMATORY Antebellum	
22d. LOCATION (City, town, or county) Hyattsville Md				22e. (State) Md		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danyanday & Son				ADDRESS 3501-14th St NW		24a. REC'D BY REGISTRAR DATE 3-21-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson				24c. (State)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03030

MARYLAND

STATE DEPARTMENT OF HEALTH

3079

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>District of Columbia</i> COUNTY	
CITY (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		CITY (if outside corporate limits, write RURAL and give nearest town) <i>47x-3</i> ✓	
TOWN <i>Silver Spring</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Summerside Nursing Home 9012 Old Road, Md. 19112</i>		STREET ADDRESS (if rural, give location) <i>1341 Adams St. N.C.</i>	
3. NAME OF DECEASED (Type or Print) <i>Elizabeth</i> (First) <i>K.</i> (Middle) <i>Hollidge</i> (Last)		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>17</i> (Year) <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED , DIVORCED, (Specify)	8. DATE OF BIRTH <i>3/26/1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>72</i> yrs. If under 1 year Months Days If under 24 hr. Hours Min.
13. FATHER'S NAME <i>Cyrus Keiser</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth H. Sweeten</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <i>578-44-5106</i>	
17. INFORMANT AND ADDRESS <i>Thomas Hollidge - 1341 Adams St. N.C. Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a)... <i>Generalized Carcinomatosis</i>			<i>1 month</i>
Antecedent cause(s) (b)... <i>Carcinoma of colon</i>			<i>4 years</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Malnutrition</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov. 22, 1956</i> , to <i>March 17, 1956</i> , that I last saw the deceased alive on <i>March 6, 1956</i> , and that death occurred at <i>10:45</i> p.m., from the causes and on the date stated above.			
SIGNATURE <i>Elmer H. Wagner, M.D.</i> (Degree or title)		ADDRESS <i>8401 University Lane, Silver Spring, Md.</i>	
DATE SIGNED <i>3/17/56</i>			
23. BURIAL, CREMATION (Specify) <i>Removal</i>		DATE <i>3-18-56</i>	
NAME OF CEMETERY OR CREMATORY <i>Washington D.C.</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <i>3-19-56</i>		REGISTRAR'S SIGNATURE <i>Francis Potter</i>	
		FUNERAL DIRECTOR <i>J. H. Lee & Sons, Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

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MAR 21 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03031

3080
CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a COUNTY Montg, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's		c. LENGTH OF STAY IN 1b 22MO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William First Lester Middle House Last		4. DATE OF DEATH Month Mar Day 25 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan 28-1889
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months 1 Days 25 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. House		14. MOTHER'S MAIDEN NAME Sarah G. Sevingle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Edith M. Joerg		Address Silverspring 11504 Galt Ave. Gaithersburg Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Lung Abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchitis (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 years 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1 Dec , 19 54 , to 23 March , 19 56 , that I last saw the deceased alive on 23 March , 19 56 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Gartner M.D.		ADDRESS (Street, city or town, state) B. J. Galt, 11504 Galt Ave. Gaithersburg Md	
DATE SIGNED 24 March 56			
PHYSICIAN'S NAME (Type) John G. Gartner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-26-56	22c. NAME OF CEMETERY OR CREMATORY Ines Cemetery	22d. LOCATION (City, town, or county) (State) Coudersport Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg Md	
24a. REC'D BY REGISTRAR DATE Mar 27/56		24b. REGISTRAR'S SIGNATURE Edith M. Joerg	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

1956

2995

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>		d. STREET ADDRESS <u>7637 Carroll Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Ann</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-80</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Griffin F. Marks</u>		14. MOTHER'S MAIDEN NAME <u>Alpha D. Bowls</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Washington San. and Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>in general failure</u> DUE TO (c) <u>renal insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>1 mo 11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-4-19</u> to <u>3-5-1956</u> that I last saw the deceased alive on <u>3-4-1956</u> , and that death occurred at <u>1:02</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H. Molohon</u>		ADDRESS (Street, city or town, state) <u>502 Underwood St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Chas H. Molohon</u>		DATE SIGNED <u>12-14-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>MAR 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM</u>	22d. LOCATION (City, town, or county) (State) <u>Rt 200 Geo Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Mathis</u>		ADDRESS <u>254 Carroll St. N.W. Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>3-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. This certificate has been signed by the attending physician and completed, filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

1871

3781

CERTIFICATE OF DEATH

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>			
c. LENGTH OF STAY IN 1b <u>7 yrs</u>				d. STREET ADDRESS <u>25 LA VELLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Late residence</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLE</u> Middle <u>ORR</u> Last <u>HUNTINGTON</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-84</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>SALEM OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES ORR</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SNYDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>DR. MARGARET H. SCOTT 25 LA VELLE DR</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BREAST CA METASTATIC TO LUNG</u> <u>110X</u> DUE TO <u>BONE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC LYMPHATIC LEUKEMIA</u> DUE TO (c) <u>CHRONIC LYMPHATIC LEUKEMIA</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>2-15</u> <u>3-27</u> <u>1956</u> Hour <u>2:15</u> P.M.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>54</u> , to <u>3-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>56</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D.				ADDRESS (Street, city or town, state) <u>7961 Eastern Ave</u>		DATE SIGNED <u>3/27/1956</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>				Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/27/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 3-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03034

3082

CERTIFICATE OF DEATH

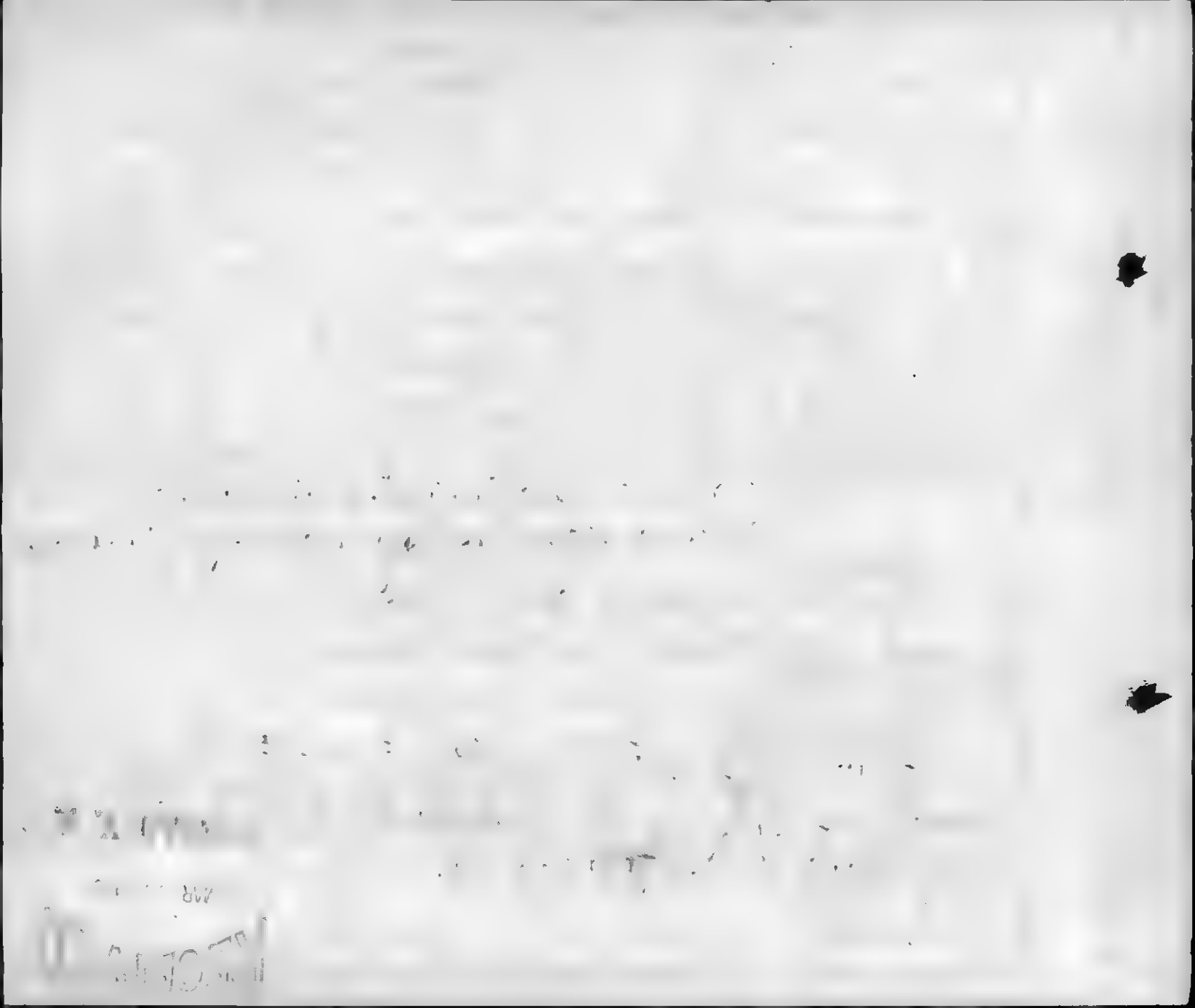
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>Viola</u> Last <u>Imes</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-99</u>
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JERRY Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Ada</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>KATHERINE DYSON - daughter</u> <u>BEAR CREEK RD. DANNINGTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and Congestive Heart Failure</u> DUE TO (b) <u>Chronic nephritis, type undetermined</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-13-56</u> , 19 <u>56</u> , to <u>3-11-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-10-56</u> , 19 <u>56</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.		DATE SIGNED <u>3/12/56</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove,</u>	22d. LOCATION (City, town, or county) (State) <u>Poplar Grove, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Williams - Poplar Rd</u>		24a. REC'D BY REGISTRAR <u>DATE 3-21-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



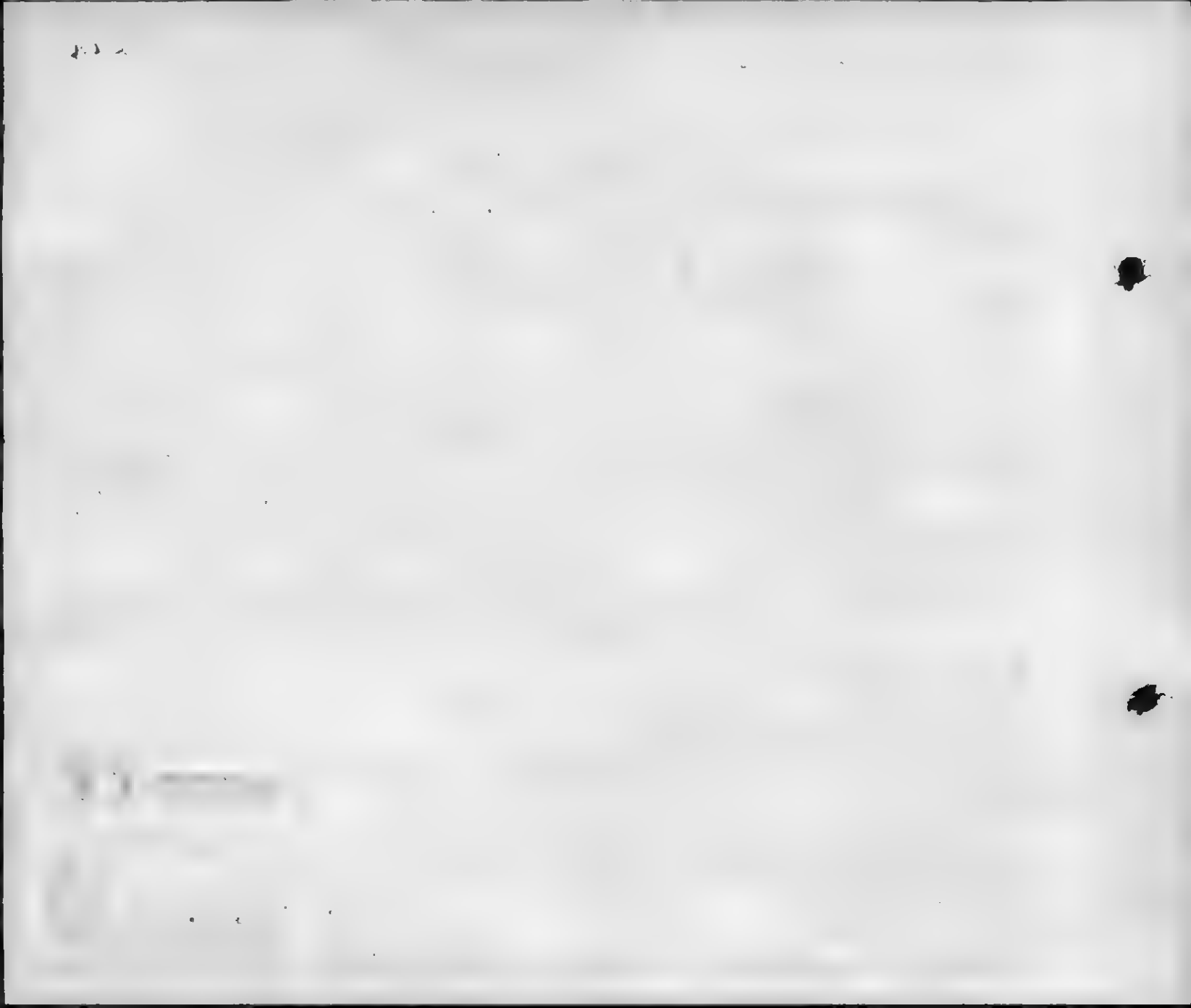
3083
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY /			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 36 minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Effie Middle Melinda Last Jackson				4. DATE OF DEATH Month March Day 7 Year 1956			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/92	
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME Caroline Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Record				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Descending Aneurysm of Aorta DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No injury							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from never , 19____, to _____, 19____, that I last saw the deceased alive on 7 March , 19 56 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis A. Craig, Jr.				ADDRESS (Street, city or town, state) 1801 K ST. N.W., Wash. D.C.			
PHYSICIAN'S NAME (Type) Louis A. Craig, Jr.				DATE SIGNED 8 Mar 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/56		22c. NAME OF CEMETERY OR CREMATORY Round Oak		22d. LOCATION (City, town, or county) (State) Spencerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swanson - Rockville, Md.				24a. REC'D BY REGISTRAR DATE 3-10-56		24b. REGISTRAR'S SIGNATURE Esther B. Fowler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1
Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
101-9, File 101-3-1-50 at
3084
CERTIFICATE OF DEATH

09036
210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kensington Gardens b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mont.Co. Nursing Home</u> c. LENGTH OF STAY in 1b <u>3 weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 McComas Ave. Kensington Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5424 MacArthur Blvd., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>L.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/1876</u>	
9. AGE (In years last birthday) <u>86</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>unobtainable</u>				14. MOTHER'S MAIDEN NAME <u>unobtainable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Wash, D.C.</u> <u>Mrs. Maude Bartoo 5424 MacArthur Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>10 days</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 9, 1956</u> to <u>1 MAR, 1956</u> , that I last saw the deceased alive on <u>1 MAR, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1714 - N. N. W. WASH. DC.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Charles W. Thompson</u> M.D.				PHYSICIAN'S NAME (Type) <u>CHARLES W. THOMPSON M.D.</u>			
22a. DATE OF REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>3/2/56</u>		<u>3/2/56</u>		<u>Sharon Cemetery</u>		<u>Hillsboro, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>3/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Otter</u>	

מסמכים 8

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INSTRUCTIONS: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

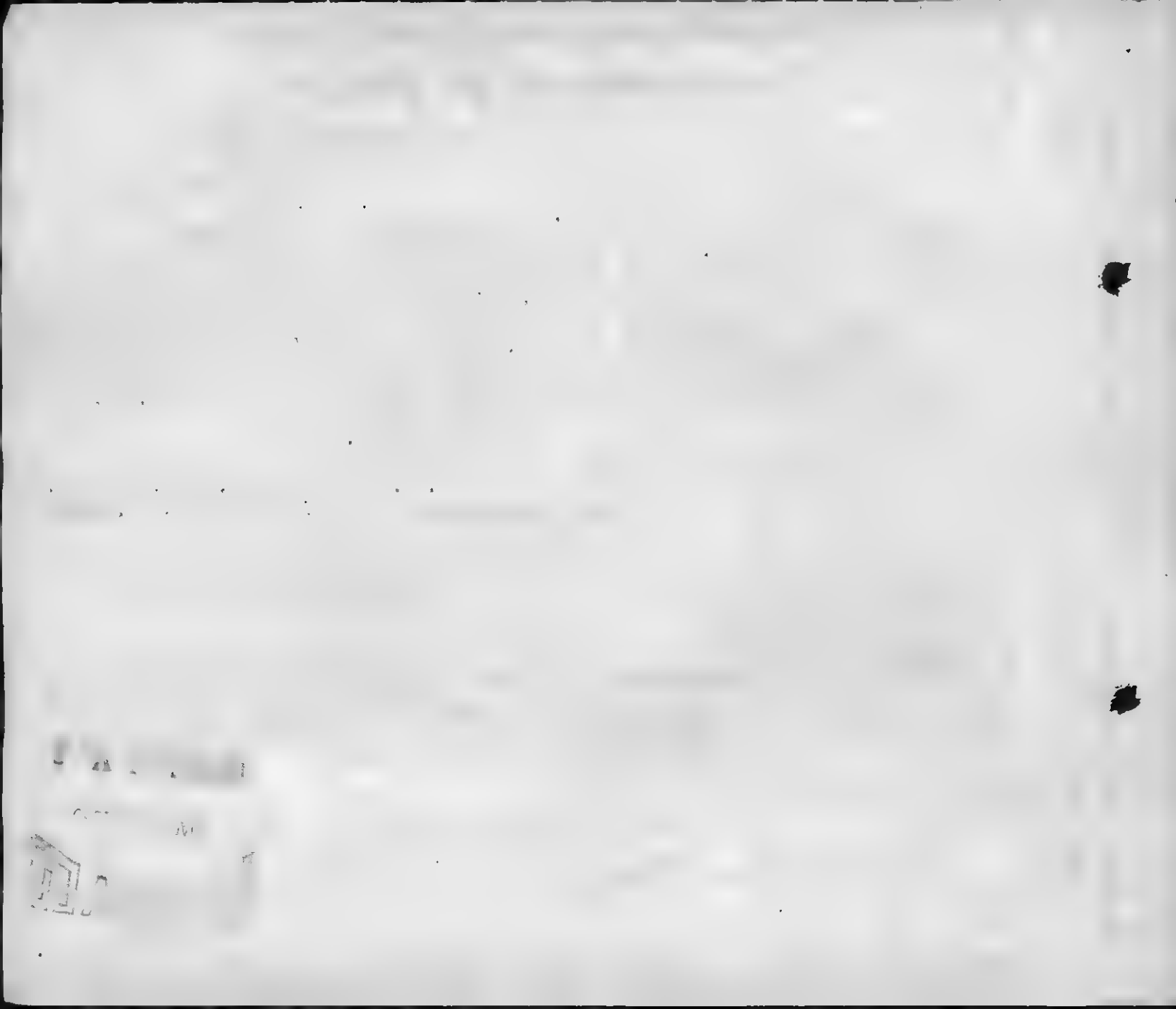
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3085 CERTIFICATE OF DEATH

03037

Reg. Dist. No. 2114

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN SILVER SPRING		14 yrs.		TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 734 EASLEY ST.				STREET ADDRESS (If rural give location) 734 EASLEY STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) McENEANEY (Last) JACOBS				(Month) MARCH (Day) 4 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	WHITE	WIDOWED	MAY 1, 1868	87 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					IRELAND		U.S.A.
13. FATHER'S NAME OWEN McENEANEY				14. MOTHER'S MAIDEN NAME BRIDGETT H. DUFFY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		NONE		Mrs. J. Frank Hushion, 734 Easley St. Silver Spring, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis				8 years.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/11/47, 1947, to 3/4, 1956, that I last saw the deceased alive on 3/4, 1956, and that death occurred at 1:00 PM, from the causes and on the date stated above.							
SIGNATURE 10730 Wadrop				ADDRESS (Street, city, town, state) 837 Bonfand St. DATE SIGNED 3/4/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 3/8/56		NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		LOCATION (City, town, or county) YEADON, PENNSYLVANIA	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 3/7/56		Francis J. [Signature]		Warner S. Humphrey		SILVER SPRING, MD.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03038

2996

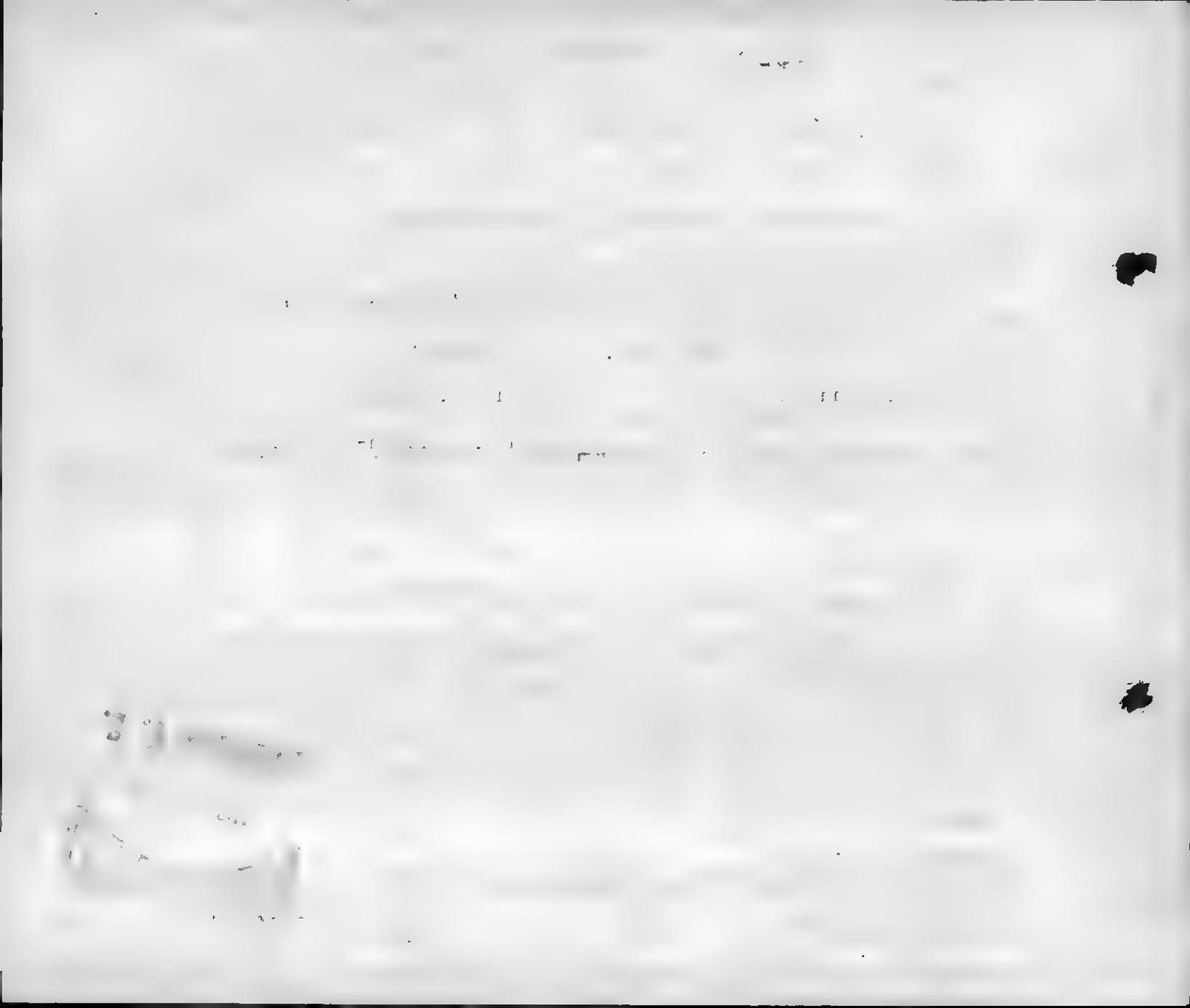
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>				d. STREET ADDRESS <u>8815-Briarley Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Edwin Johnson</u>				4. DATE OF DEATH Month Day Year <u>March 29 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1898</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape gardening</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver G. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Ida J. Custer</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Sarah A. Johnson-Item# 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>40.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>perforated peptic ulcer of stomach</u> DUE TO <u>12 hours</u> (c) <u>peptic ulcer - essential hypertension</u> <u>15 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19 March</u> , 19 <u>56</u> , to <u>29 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 March</u> , 19 <u>56</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd Bethesda 14, Maryland</u> DATE SIGNED <u>30 March 56</u>							
ACTUAL SIGNATURE <u>John M. Wyman</u>				M.D. <u>John M. Wyman M.D.</u>			
PHYSICIAN'S NAME (Type) <u>John M. Wyman M.D.</u>				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-2-56</u>		<u>Monocacy</u>		<u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>7557th Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>3/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson Bird</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3086

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hilton Village</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing</u>		d. STREET ADDRESS <u>301 Pungituit</u>	
3. NAME OF DECEASED (Type or print) <u>ADA</u> First <u>C</u> Middle <u>KRAUSE</u> Last		4. DATE OF DEATH <u>March</u> Month <u>4</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10/1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired store keeper sup</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chis</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob D Krause</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>121111111</u>	
17. INFORMANT <u>Just H Krause</u>		Address <u>Kensington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Nov</u> <u>am</u> <u>19</u> p. m.		20d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not while</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1 March</u> , 19 <u>56</u> , and that death occurred at <u>3:05</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morton L. White</u>		ADDRESS (Street, city or town, state) <u>11134 Georgia Ave S.S. Md</u>	
PHYSICIAN'S NAME (Type) <u>Morton L. White</u>		DATE SIGNED <u>March 56</u>	
22a. BURIAL, CREMATION, REMOVAL <u>Transportation</u>		22b. DATE THEREOF <u>3/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Transportation</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Garcke</u>		ADDRESS <u>Some Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>6</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. A. OVERSEA

1914

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2997

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>4 wks. 6 days</u>				d. STREET ADDRESS <u>1437 Whittier St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Loula</u> First <u>Lampiris</u> Middle Last				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-16</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Gus Picoules</u>				14. MOTHER'S MAIDEN NAME <u>Latherine -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <u>Medical Records - Washington San. & Hosp.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Perforation of Ulew of the Sigmoid</u> (c) <u>Pericarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sclero derma - 8+ years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>2 1/2 days</u> <u>2 wks.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/22/1956</u> , to <u>3/27/1956</u> , that I last saw the deceased alive on <u>March 27, 1956</u> , and that death occurred at <u>9:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. HARE, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich Funeral Home</u> ADDRESS <u>4817 1/2 Ave N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>3/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3087 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5209 Rayland Drive</u>		d. STREET ADDRESS <u>5209 Rayland Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>RYENZA</u> Middle <u>SCOTT</u> Last <u>LANGLEY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1895</u>
9. AGE (In years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Vet. Adm. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert W. Scott</u>	
14. MOTHER'S MAIDEN NAME <u>Anna V. Yancey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ione S. Ebrite - Sister</u> Address <u>Bethesda Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respir. failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous</u> DUE TO (c) <u>Adenocarcinoma of colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 1/2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1954</u> , to <u>3/2/56</u> , that I last saw the deceased alive on <u>3/2/56</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u>		ADDRESS (Street, city or town, state) <u>Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES, M.D.</u>		DATE SIGNED <u>3/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1976

3088

CERTIFICATE OF DEATH

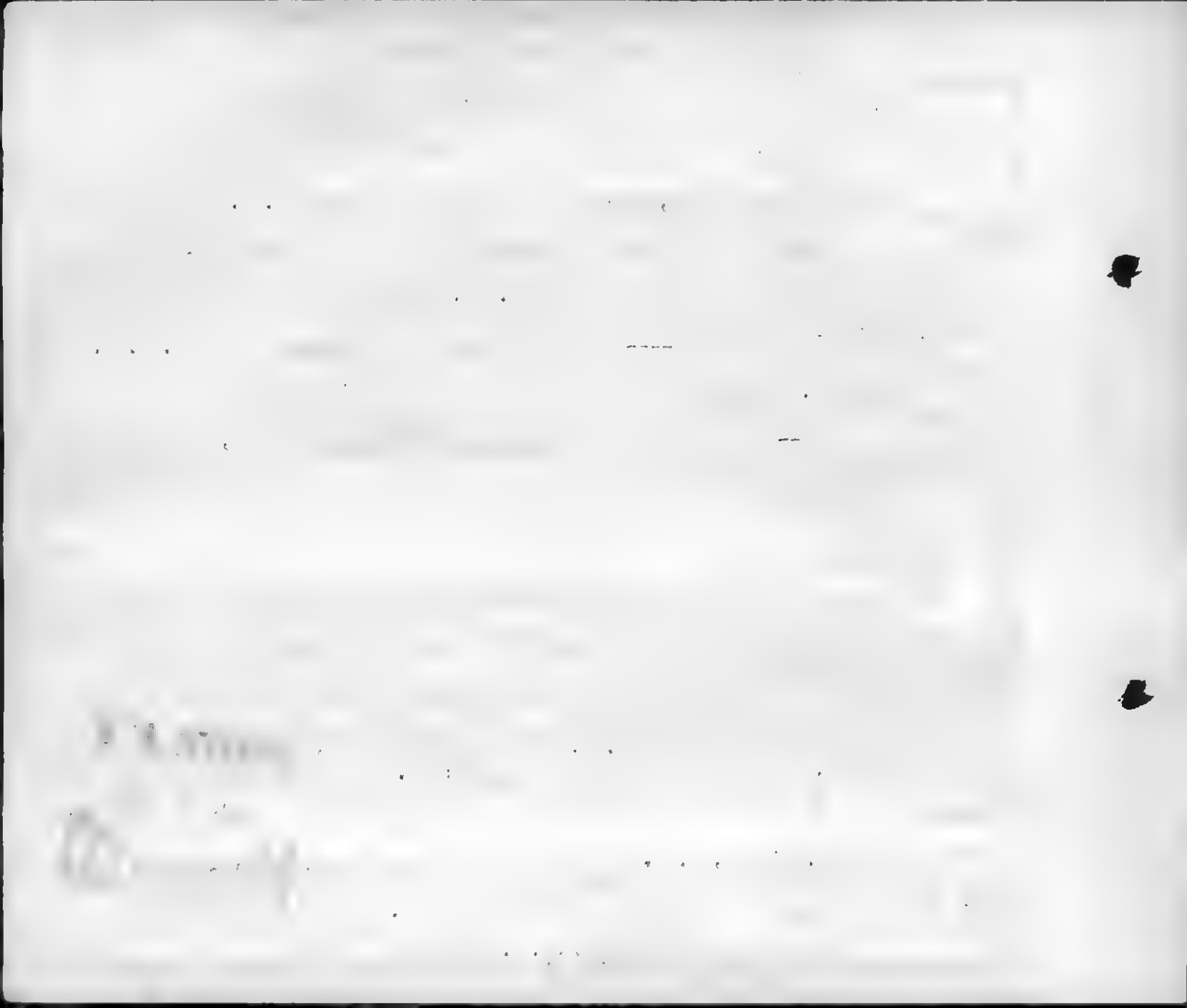
Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda				d. STREET ADDRESS 2801 Curtis Drive, S. E.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Alan Langtry				4. DATE OF DEATH March 22, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1954		9. AGE (In years (last birthday) yrs) 2	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Langtry				14. MOTHER'S MAIDEN NAME Shirley Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 1956 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Cystic Fibrosis of the Pancreas DUE TO (c) Congenital						INTERVAL BETWEEN ONSET AND DEATH Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2, 1956 , to March 22, 1956 , that I last saw the deceased alive on March 22, 1956 , and that death occurred at 6:35 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis E. Gibson				M.D. The Clinical Center, National Institutes of Health			
PHYSICIAN'S NAME (Type) Lewis E. Gibson, M. D.				Bethesda, Maryland 3/22/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/26/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. News Co.				ADDRESS 2001 14th St. N. W.		24a. REC'D BY REGISTRAR DATE 3-24-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUNOCO GAS STATION				d. STREET ADDRESS 730 SILVER SPRING AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First OCTAVIUS Middle U Last LARSEN				4. DATE OF DEATH Month MARCH Day 29 Year 19 56				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/83		
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER - Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-03-8607		17. INFORMANT Address Mrs. Helen Larsen, 730 Silver Spring Ave. Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <u><i>Coronary occlusion</i></u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u><i>Sudden</i></u> DUE TO</p> <p>(c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u><i>Frank J. Broschart</i></u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/31/56		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE <u><i>Warner B. Humphrey</i></u> ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/3/56		24b. REGISTRAR'S SIGNATURE <u><i>James L. ...</i></u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03044

3090

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>4512 Chestnut St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wladimir Wassiljevitch Lepeschkin</u>		4. DATE OF DEATH <u>March 22</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Moscow, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wassili Lepeschkin</u>		14. MOTHER'S MAIDEN NAME <u>Alexandra Kotor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophosis</u> DUE TO (c) <u>Hypertrophied Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced General Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 March, 1956</u> , to <u>22 March, 1956</u> , that I last saw the deceased alive on <u>22 March, 1956</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Ball</u>		ADDRESS (Street, city or town, state) <u>7936 Georgetown Rd. Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		DATE SIGNED <u>22 March 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>8-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	



1 1 1



9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03045
Reg. Dist.

No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Montg</i>
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <i>Takoma Park</i>	LENGTH OF STAY (in this place) <i>30 yrs</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Takoma Park</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>512 New York Ave</i>		STREET ADDRESS (If rural, give location) <i>512 New York Ave</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <i>Ernest Mathew</i> (Middle) <i>Linthicum</i> (Last)		(Month) <i>Mar</i> (Day) <i>22</i> (Year) <i>1956</i>	
5. SEX: <i>ma</i>	6. COLOR OR RACE: <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>11-25-1886</i>
9. AGE last birthday: <i>69</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Government</i>	
11. BIRTHPLACE (State or foreign country): <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>JOSHUA LINTHICUM</i>		14. MOTHER'S MAIDEN NAME: <i>ELIZA WHITE</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>512 NEW YORK AVE, MRS MAY B. LINTHICUM, TAKOMA PARK, MD.</i>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Asphyxia</i> DUE TO			<i>Found dead in basement of his home</i>
Antecedent cause(s) (b) <i>hanging</i> DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
<i>Takoma Park Montg md</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3-22-56 4 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>hanging self by mechanical wire</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Frank J. Bruchant</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>3-22-56</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>	DATE THEREOF <i>MAR 24 1956</i>	NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>	LOCATION (City, town, or county) (State) <i>BADEN BARBER, IRTOE CO., MD.</i>
DATE REC'D BY LOCAL REG. <i>3/23/56</i>	REGISTRAR'S SIGNATURE <i>J. H. H. H. H.</i>	24. FUNERAL DIRECTOR <i>J. H. H. H. H.</i> ADDRESS <i>254 CARRILL ST. N. W., TAKOMA PARK, D.C.</i>	

S. A. [illegible]



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3020

03046

Reg. Dist. No. 213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) TOWN <u>Rockville</u>		RURAL <u>Yes</u> LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>323 Lincoln Ave</u>				STREET ADDRESS (If rural, give location) <u>323 Lincoln Ave</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Robert</u>		(Middle) <u>Lucas</u>		(Last) <u>Lucas</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>Jan 27 - 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>1</u> yrs. <u>1</u> Month <u>11</u> Days		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Robert N. Lucas</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Clara Lucas (mother) Home & Room 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
4" X Immediate cause (a) <u>Asphyxia</u> DUE TO Antecedent cause(s) (b) <u>Asphyxia</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>supper Respiratory Insufficiency</u>						<u>Found dead in bed</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. B. Schacht</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-8-56 M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>3-12-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Lincoln Park</u>		LOCATION (City, town, or county) (State): <u>Rockville, Ind.</u>	
DATE REC'D BY LOCAL REG. <u>3/12/56</u>		REGISTRAR'S SIGNATURE: <u>Lamell H. Grayson</u>		24. FUNERAL DIRECTOR: <u>Robert L. Sworden</u>		ADDRESS: <u>Rockville, Ind.</u>	



1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3091
CERTIFICATE OF DEATH

03047
 Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Glenn Rice Lyerly</u>				4. DATE OF DEATH <u>March 4</u> 19 <u>56</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1922</u> 33 yrs.	
9. AGE (In years last birthday) <u>33</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Haynes lithograph</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Walter Lee Lyerly</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Correll</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister Miriam Williams</u>		Address <u>North garden, Va.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, 1st Anterior + Septum</u> DUE TO <u>Acute Ant. Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>3/3/56</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>3/3/56</u> , 19____, and that death occurred <u>at 12:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Witowski, M.D.</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI, JR. M.D.</u>				DATE SIGNED <u>3/5/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Trans</u>		22b. DATE THEREOF <u>3-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unity Presby Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury No. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>3-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital and the attending physician. TO FUNERAL DIRECTOR: After this date has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

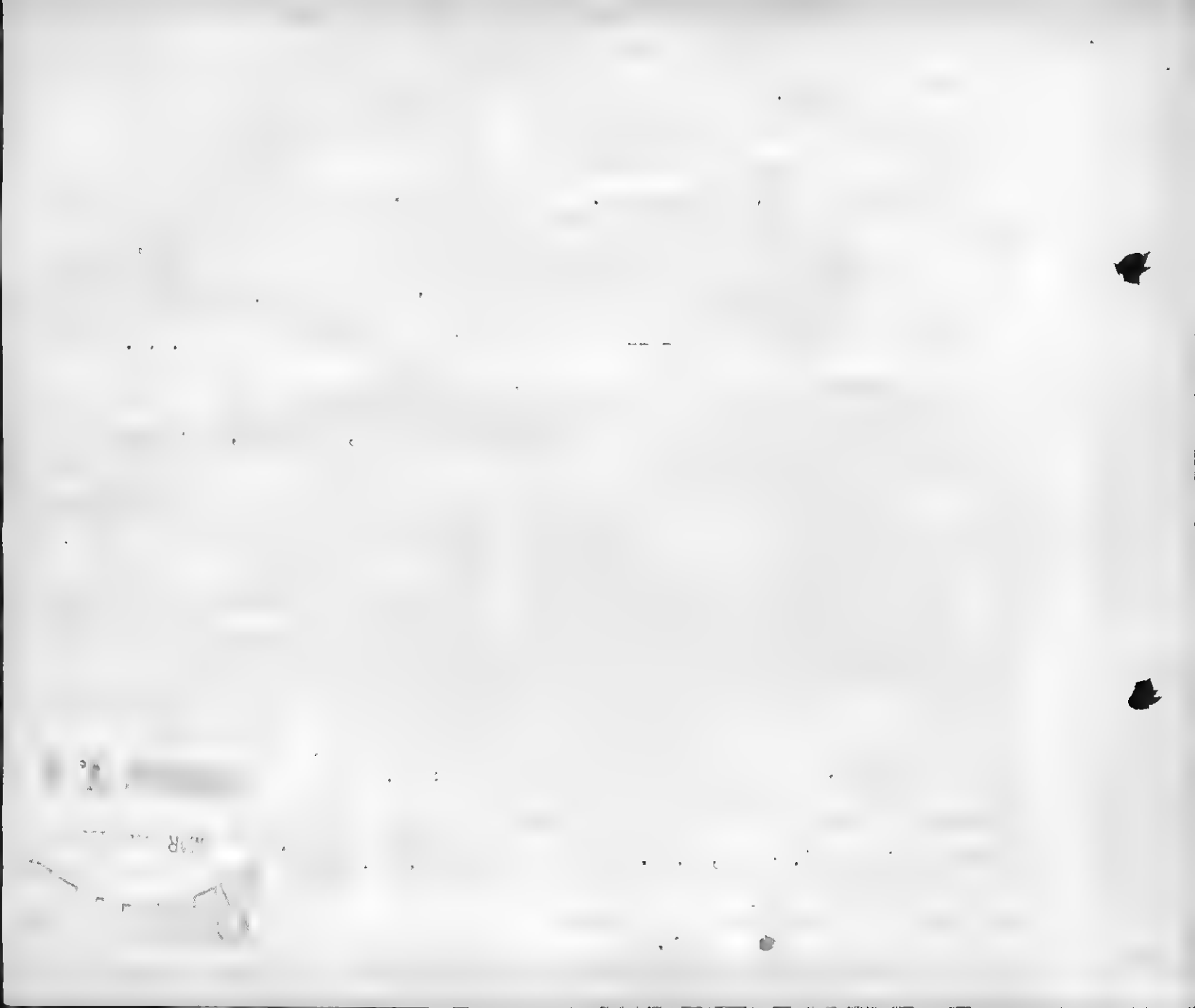
3092

CERTIFICATE OF DEATH

03048

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) ON INSTITUTION The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 3073 S. Woodrow Street	
3. NAME OF DECEASED (Type or print) First Middle Last Mark James Marotta		4. DATE OF DEATH Month Day Year March 19, 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1954
9. AGE (In years last birthday) 16 mos		IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Marotta		14. MOTHER'S MAIDEN NAME June Mortlock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas pneumoniae & septicaemia DUE TO Septic Meningitis & Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO Torcular Hemophili (c) Torcular Hemophili			INTERVAL BETWEEN ONSET AND DEATH 4 day 3 moth 2 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----	20f. (City or town) (County) (State) ----
21. I certify that I attended the deceased from February 17, 19 56 , to March 19, 19 56 , that I last saw the deceased alive on March 19, 19 56 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard D. Fritz M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3 Peaks Hill Rd, Bethesda, Md 3-14-56	
PHYSICIAN'S NAME (Type) Richard D. Fritz, M.D.		The Clinical Center, NIH Bethesda, 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipment	22b. DATE THEREOF 3-20-56	22c. NAME OF CEMETERY OR CREMATORY GRACELAND Cem.	22d. LOCATION (City, town, or county) (State) Albany, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Lee		ADDRESS Arlington 1, D.C.	
24a. REC'D BY REGISTRAR 3-21-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	



3093

03049
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 212

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Dickerson LENGTH OF STAY (in this place) 4 days
TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Montg
CITY (If outside corporate limits write RURAL and give nearest town) Dickerson
OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

James Franklin Martin

4. DATE OF DEATH

(Month)

(Day)

(Year)

Mar 22 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

m W Married 6-6-1885 70 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

Coronary occlusion

DUE TO

Antecedent cause(s)

(b).....

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. BroschartCHIEF MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐

M. D.

ASSISTANT MEDICAL EXAM. ☐3-22-56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/23/56Charles W. Elgin per D.F.E.William B. HellenBerwynville, Md.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. S.

1944

1944

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03050

3094 CERTIFICATE OF DEATH

Reg. Dist. No. 4.18

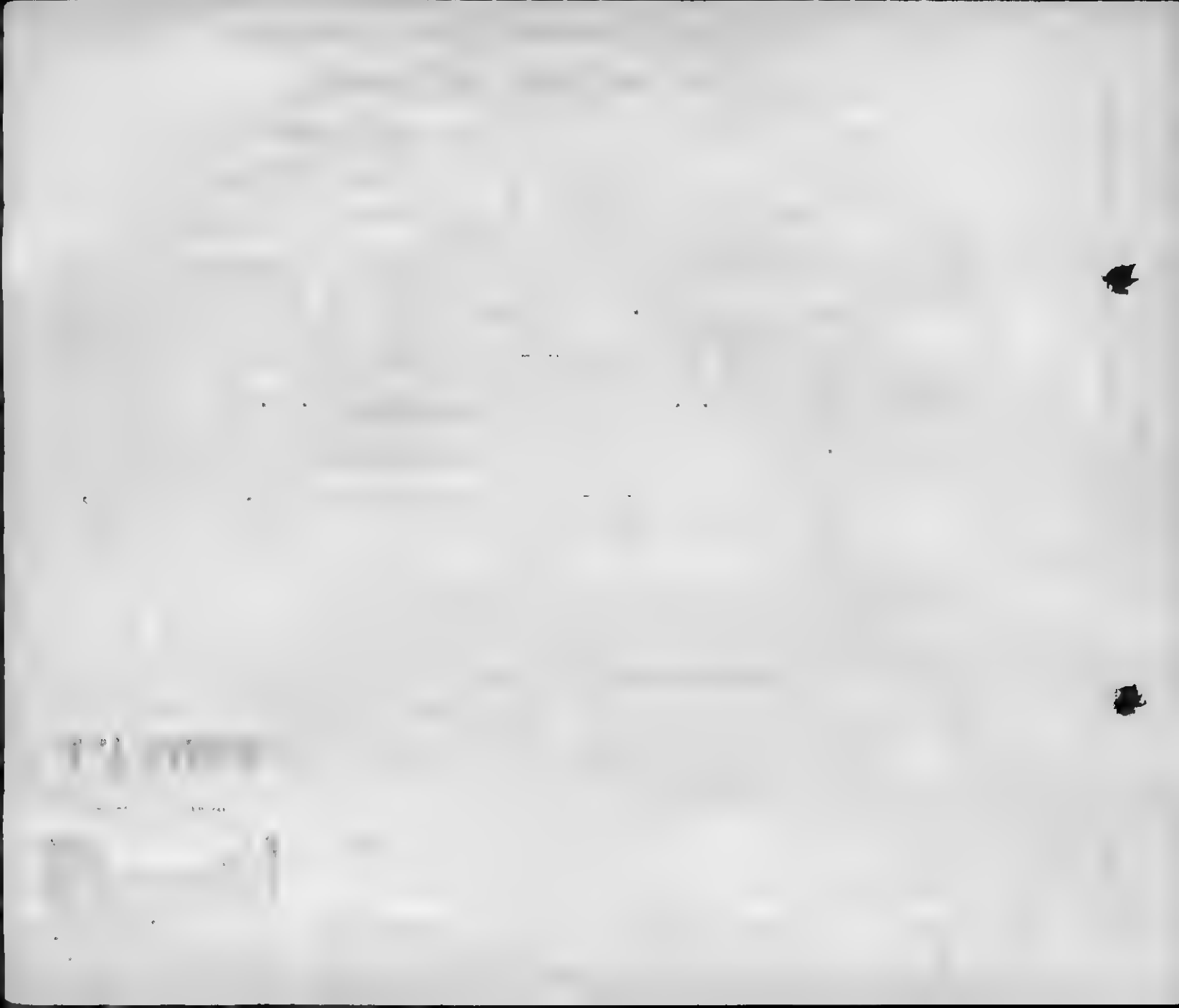
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gaithersburg</u>		<u>1 year</u>		TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Marylander</u>				STREET ADDRESS (If rural give location) <u>4506 Edgefield Road</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Anna</u> (Middle) <u>E.</u> (Last) <u>May</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 7 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-2-88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. McGill</u>				14. MOTHER'S MAIDEN NAME <u>Mary Linskey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>075-51-7775</u>		17. INFORMANT & ADDRESS <u>Mrs. Emily Sullivan 4506 Edgefield Rd. Kensington, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3, 1955</u> to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>March 6, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James P. Kern</u>		M.D. <u>Hamascus, Md.</u>		DATE SIGNED <u>3/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR <u>Mar. 10-56</u>		REGISTRAR'S SIGNATURE <u>Lillian L. Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>Wash. DC 3-21-14th St. N.W.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the final copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A 1-55 10M



3095

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blattsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15 Miller St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>S</u> Last <u>McLadden</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Beaulieu</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Fouchier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Frank R. McLadden</u>		Address <u>15 Miller St. Blattsburg, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>1 week</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, Januaries due to common</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart Failure</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/24/56</u> to <u>March 3 1956</u> that I last saw the deceased alive on <u>March 3 1956</u> and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>11301 Georgia Ave. Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		DATE SIGNED <u>3/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>	22b. DATE THEREOF <u>3/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PLATTSBURG, CLINTON CO., N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner & Humphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. This certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3096

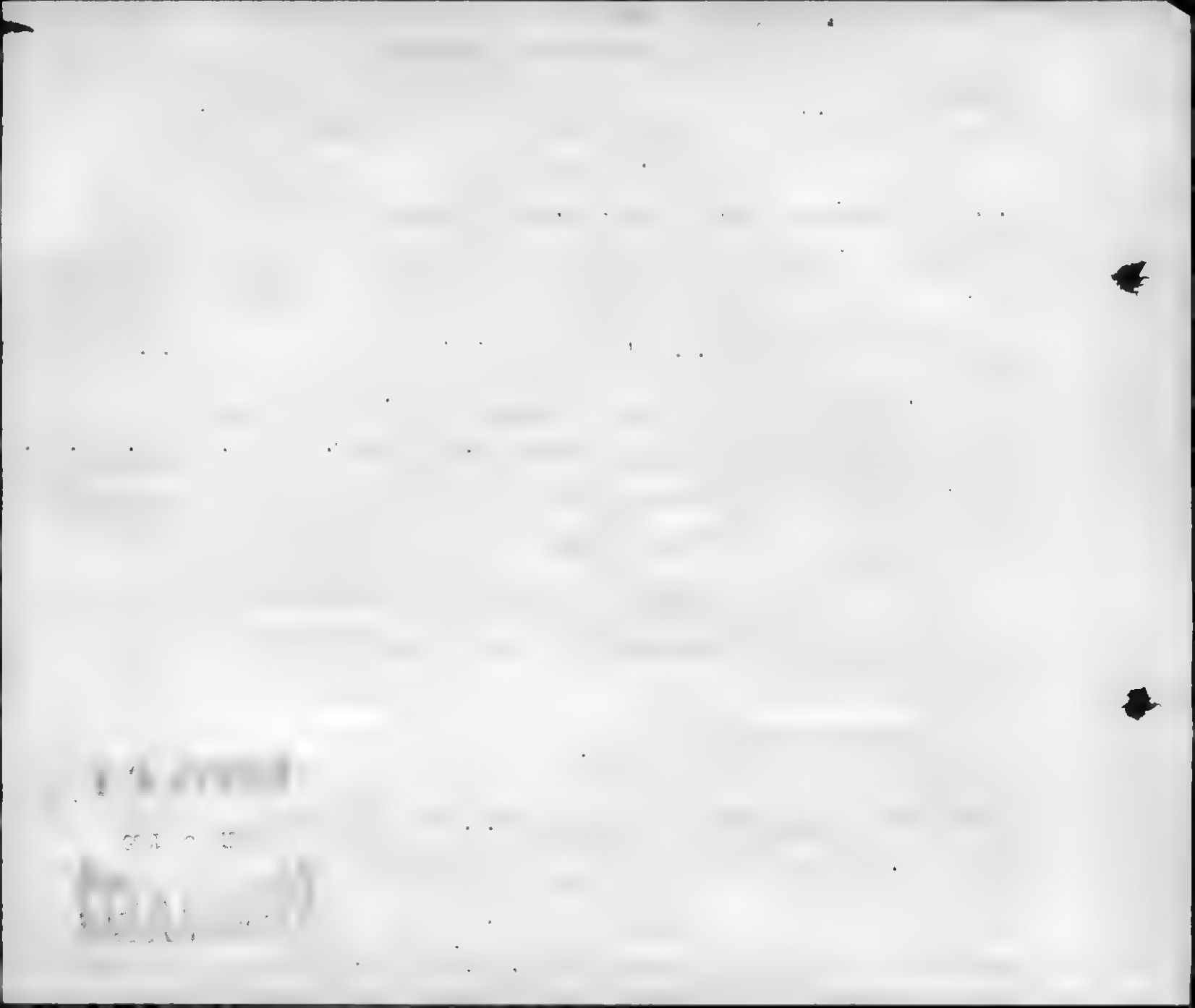
CERTIFICATE OF DEATH

03052

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ret'la la (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, INMC, Bethesda, Md.</u>				d. STREET ADDRESS <u>1983 S. George Mason Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Miles</u> Last <u>MC COOL</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 July 1885</u>	
9. AGE (In years last birthday) yrs <u>70</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>56</u>		IF UNDER 24 HRS Months <u>7</u> Days <u>19</u> Hours <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. COV'T</u>		11. BIRTHPLACE (State or foreign country) <u>Mississirpi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George W. MC COOL</u>				14. MOTHER'S MAIDEN NAME <u>Georgia A. RAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Richard M. MC COOL Jr.</u> Address <u>1983 Geo. Mason Dr. Arl. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Infestation</u> DUE TO <u>Thrombo phlebitis - left leg.</u> Conditrans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombo phlebitis - left leg.</u> (c) <u>Bronchio genic Carcinoma - left lung with metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchio genic Carcinoma - left lung with metastasis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>16 Jan.</u> , <u>1956</u> , to <u>7 March</u> , <u>1956</u> , that I last saw the deceased alive on <u>7 March</u> , <u>1956</u> , and that death occurred at <u>1:04 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Maryland</u> DATE SIGNED <u>3-7-56</u>							
ACTUAL SIGNATURE <u>A. J. Capelletti</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>A. J. CAPPELLETTI, LCDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gettysburg, Penna. Private</u>		22d. LOCATION (City, town, or county) (State) <u>Gettysburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons Co.</u>				ADDRESS <u>Arlington, DC</u>		24a. REC'D BY REGISTRAR <u>DATE 7 Mar. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harry E. Passell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

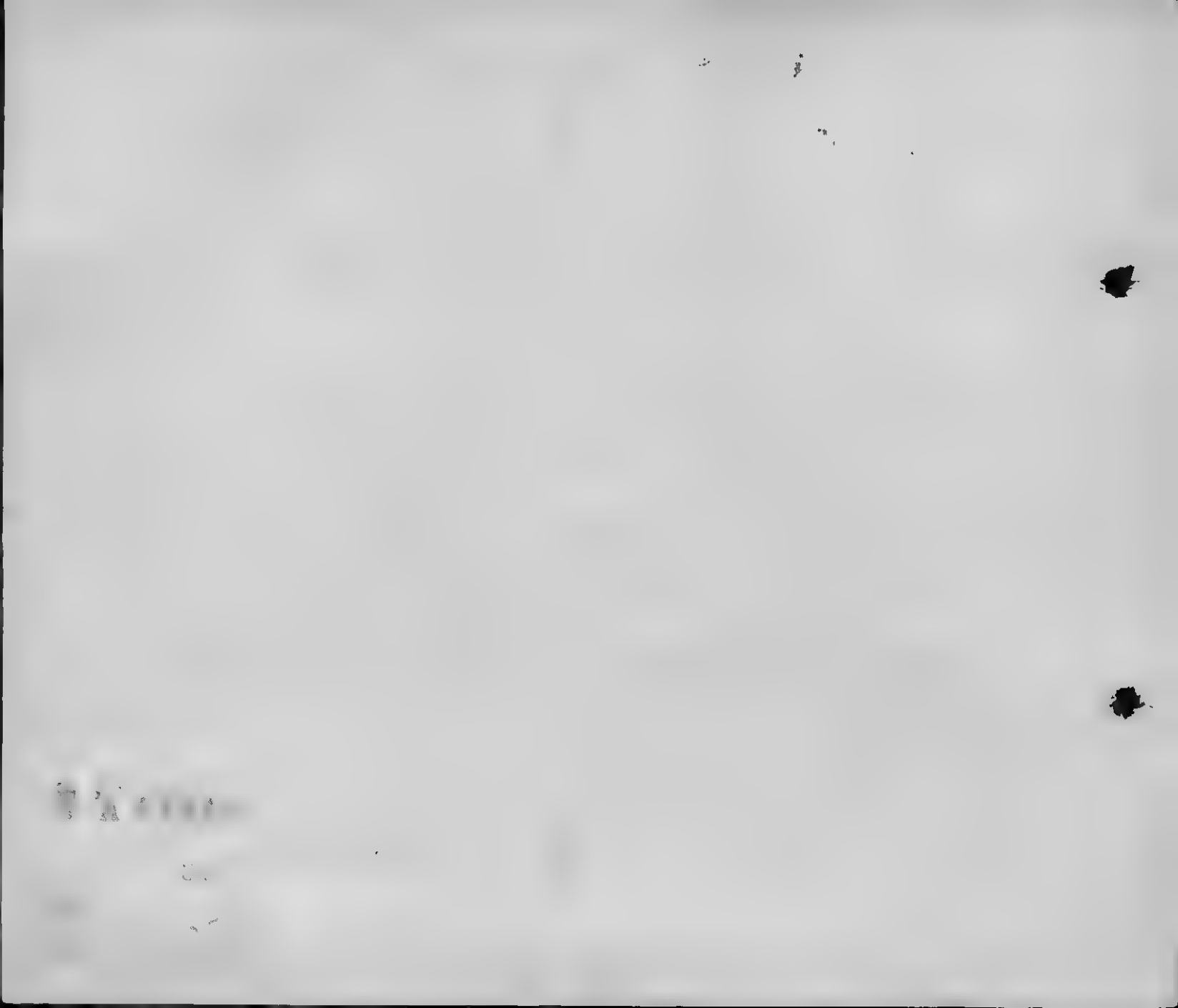
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03053

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8908 Melwood Rd</u>				STREET ADDRESS (If rural, give location) <u>8908 Melwood Rd</u>			
3. NAME OF DECEASED: (First) <u>Thomas</u> (Middle) <u>Rutledge</u> (Last) <u>McCoy</u>		4. DATE OF DEATH (Month) <u>mar</u> (Day) <u>4</u> (Year) <u>1956</u>		5. SEX: <u>m</u>		6. COLOR OR RACE: <u>w</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>0-30-47</u>		9. AGE last birthday: <u>8</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Student</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas J. McCoy</u>				14. MOTHER'S MAIDEN NAME: <u>Mary A. Rutledge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Father, Thomas J. McCoy, 8908 Melwood Rd. Beth. Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>Found dead</u>	
Immediate cause (a) <u>Asphyxia</u>							
DUE TO							
Antecedent cause(s) (b) <u>Hanging</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>home</u>		21c. (City or town) (County) (State) <u>Bethesda Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-7-56 4:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from chain with clothesline about neck</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Brossi</u>		M. D.		DATE SIGNED <u>3-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockville, Montg. Md</u>	
DATE REC'D BY LOCAL REG. <u>3-5-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	



3098

CERTIFICATE OF DEATH

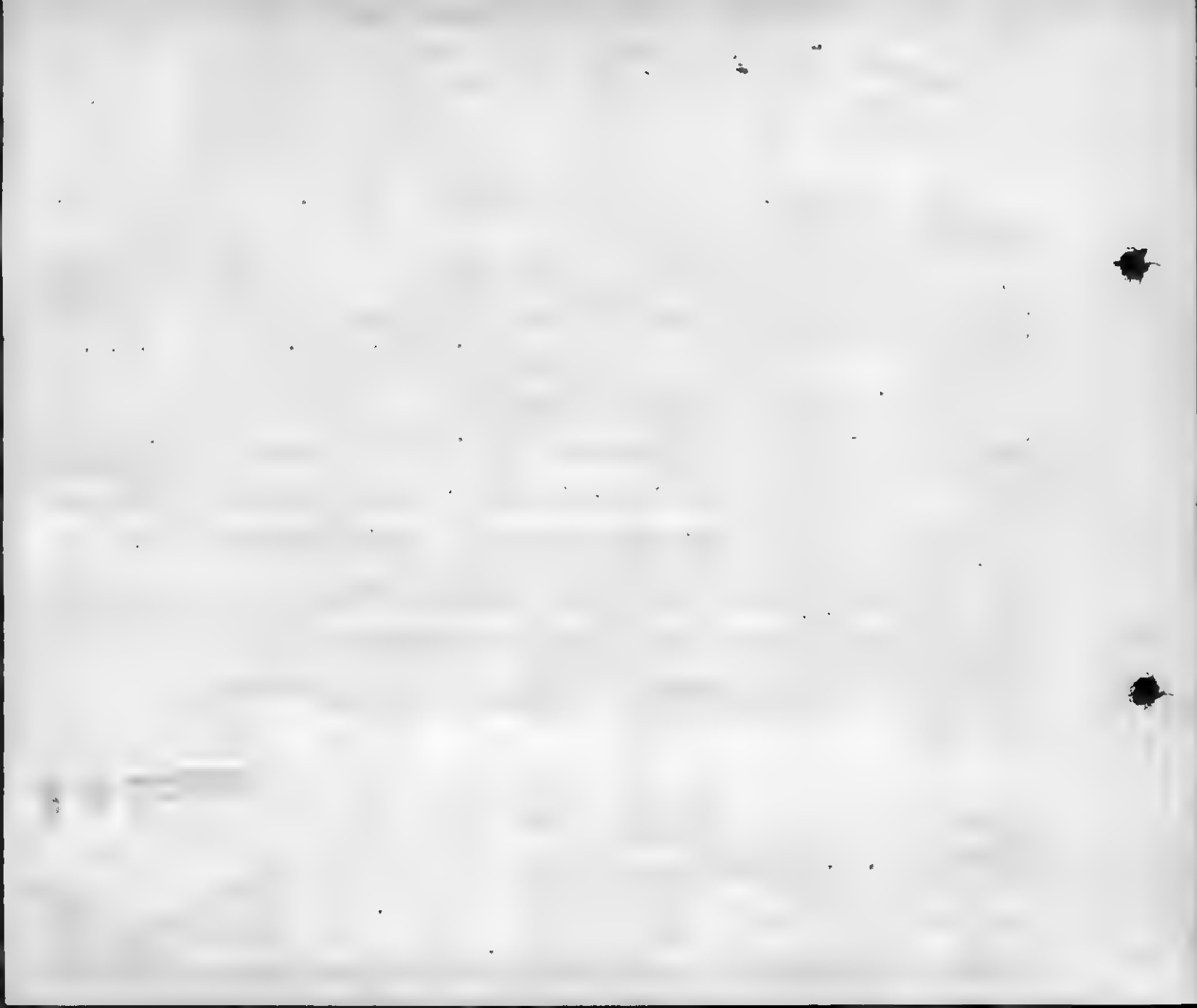
03054

Reg. Dist. No.

276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wood Acres		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wood Acres	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6004 Cobalt Rd.		d. STREET ADDRESS 6004 Cobalt Rd.	
3. NAME OF DECEASED (Type or print) First Alice Middle Miles Last Meyer		4. DATE OF DEATH Month March Day 16 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/88
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Paul, Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus L. Miles		14. MOTHER'S MAIDEN NAME Nellie Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Merle F. Meyer		Address 6004 Cobalt Rd. Wood Acres, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 40-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Coronary sclerosis			INTERVAL BETWEEN ONSET AND DEATH hours years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-22-1952 to 3-14-1956 , that I last saw the deceased alive on 3-14-1956 , and that death occurred at 7 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. P. Ryland		ADDRESS (Street, city or town, state) C. P. Ryland, 4400 14th St., N. W., Washington 16, D. C.	
DATE SIGNED 3-16-56			
PHYSICIAN'S NAME (Type) C. P. Ryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/20/1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE John S. W. Hines Co.		ADDRESS 2901 14th St. N. W.	
24a. REC'D BY REGISTRAR DATE 3-19-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



3099

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>				d. STREET ADDRESS <u>4504 Burlington Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Nannie E</u> Middle <u>Michael</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1863</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Flammig</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Myron M Michael</u> Address <u>Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emmocation + Coarctation</u> <u>1144</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uterine ca - Metastases</u> DUE TO (c) <u>Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour <u>a. m.</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>3-18</u> , 19 <u>55</u> , to <u>3-20</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3-20-56</u> , 19 <u></u> , and that death occurred at <u>7:39 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosken Ziegler</u> M.D. <u>Olney, Md</u>				DATE SIGNED <u>3-20-56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEN ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guschione</u>				ADDRESS <u>Hyattsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-21-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Estimote B Lawley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11-11-11

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03056

3100

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda,</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Approx 7 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>National Institutes of Health</u>				d. STREET ADDRESS <u>9618 Cottrell Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>A</u> Last <u>MOKREN</u> <u>Mokren</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1948</u>		9. AGE (In years last birthday) <u>7</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(child)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Mokren</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Frank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Shirley Mokren (Same as deceased)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomembranous enterocolitis</u> <u>5743</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute leukemia</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhagic ascites</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace Wright Bernton</u>				ADDRESS (Street, city or town, state) <u>Clinical Center Bethesda, Md.</u>		DATE SIGNED <u>3/24/56</u>	
PHYSICIAN'S NAME (Type) <u>Horace Wright Bernton, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Mary's, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Turner</u>				ADDRESS <u>4217-9145th NW</u>		24. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. B.

MAR 23

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2999

CERTIFICATE OF DEATH

Reg. Dist. No.

030573

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
f. STREET ADDRESS <u>7312 16th Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Trene</u> Middle <u>Maude</u> Last <u>Fuller</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>14</u> - Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1886</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Clerk Typist - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas Wingrove</u>			
14. MOTHER'S MAIDEN NAME <u>Mary E. Coudy</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>577-20-5725A</u>				17. INFORMANT <u>Washington Sanitarium & Hospital Records, TX, TX</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>ARTERIOSCLEROTIC HT DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u> <u>2 1/4 MOS</u> <u>3-4 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>56</u> , to <u>MARCH 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 13</u> , 19 <u>56</u> , and that death occurred at <u>2:05</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Harold Sterling</u>				ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY LANE, HYATTSVILLE, MD.</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				DATE SIGNED <u>3/14/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumpfory S.S., Md.</u>				ADDRESS <u>8434 44th Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



3700
CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>8203 17th Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Mullery</u>				4. DATE OF DEATH <u>3</u> <u>18</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-74</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>LN KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Washington Sanitarium & Hospital Record</u>				Address <u>Takoma Park Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure due to diabetes</u>							
DUE TO (b) <u>Broncho pneumonia</u>							
DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1, 1956</u> , to <u>March 18, 1956</u> , that I last saw the deceased alive on <u>March 17, 1956</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>8401 University Lane, S.E., Ind.</u>			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				DATE SIGNED <u>3/18/56</u>			
22a. PLACE OF CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Stark</u>		<u>3/18/1956</u>		<u>Calvary Cemetery</u>		<u>Queens County, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>1400 Chapin St N Wash, D.C.</u>			
24a. REC'D BY REGISTRAR <u>3/10/56</u>				24b. REGISTRAR'S SIGNATURE <u>J. H. ...</u>			

TO HOSPITAL OR FUNERAL HOME: The form required by the State Department of Health for the purpose of recording deaths shall be retained by the hospital or funeral home for a period of one year after the date of death. The form shall be retained by the hospital or funeral home for a period of one year after the date of death. The form shall be retained by the hospital or funeral home for a period of one year after the date of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

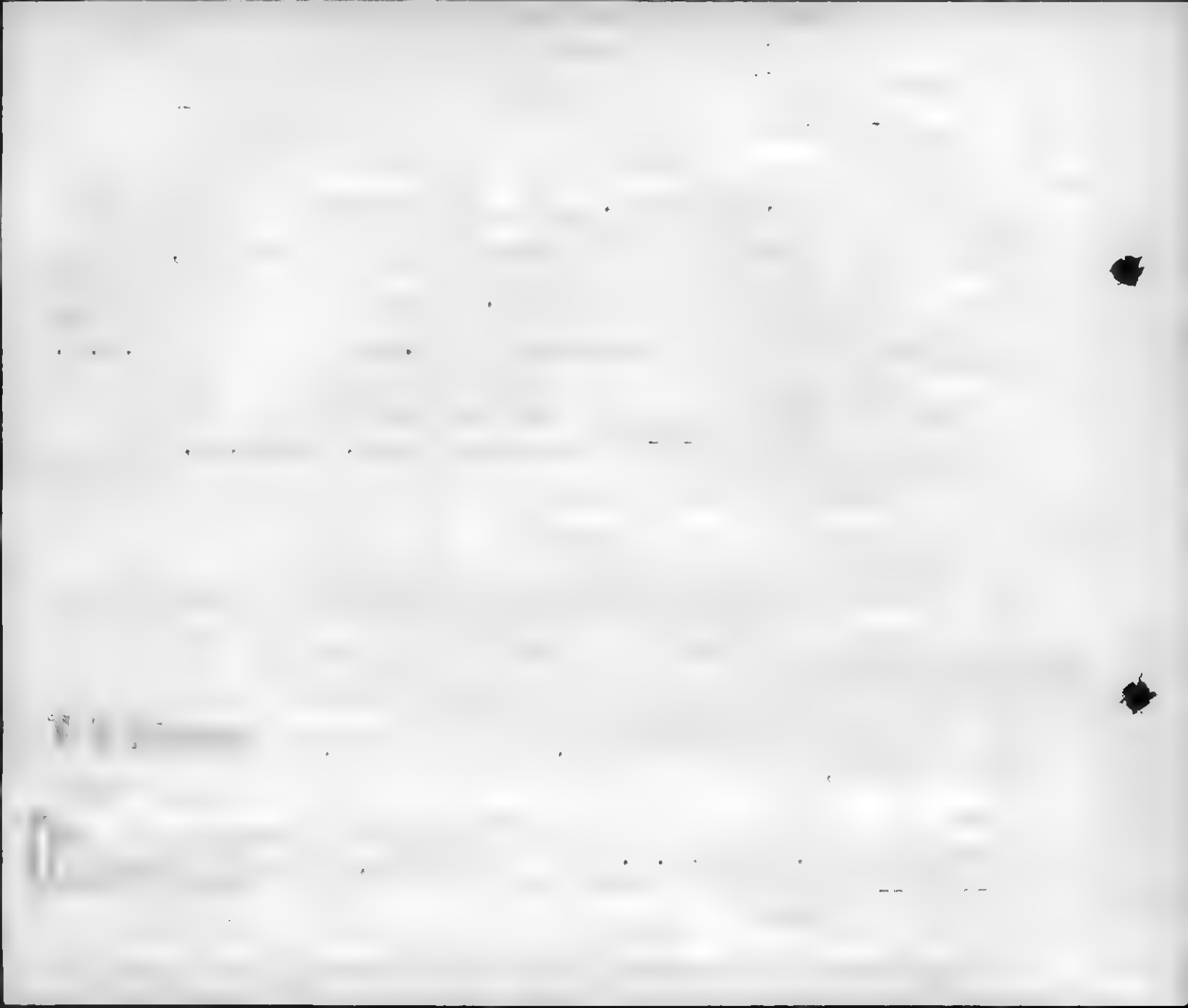
3101

CERTIFICATE OF DEATH

03059

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown			
c. LENGTH OF STAY IN 1b 17 days				d. STREET ADDRESS 815 East Avenue "E"			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elmer Middle Glenn Last Murphy				4. DATE OF DEATH Month March Day 22 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1913	9. AGE (In years for birthday) 42 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer Murphy				14. MOTHER'S MAIDEN NAME Jennie Bordner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 332-10-5866		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) POST-OPERATIVE (c) AORTIC INSUFFICIENCY, RHEUMATIC							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour _____ p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 5, 1956 to March 22, 1956 , that I last saw the deceased alive on March 22, 1956 , and that death occurred at 2:02 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Salerno		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health		DATE SIGNED 3/23/56	
PHYSICIAN'S NAME (Type) Robert A. Salerno, M. D.		BETHESDA, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 3/24/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Lewistown, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS Wash, D.C. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 3-26-56		24b. REGISTRAR'S SIGNATURE Burris M. Thompson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3001

CERTIFICATE OF DEATH

03060

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 wks. 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4 1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William H. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Suhre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1</u>			
17. INFORMANT <u>Medical Records Washington San. and Hosp.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Advanced Carcinoma of Duodenum</u> DUE TO <u>Advanced Carcinoma of Duodenum 2 Ascites</u> (b) <u>Diabetes Mellitus (severe)</u> DUE TO <u>Chronic Nephritis</u> (c) <u>Advanced Arteriosclerosis + Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Left Hemiplegia</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>4 yrs.</u> <u>14 yrs.</u> <u>6 mos</u> <u>13 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1958</u> 19 <u>58</u> to <u>3-27</u> 19 <u>56</u> , that I last saw the deceased alive on <u>March 27</u> 19 <u>56</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr. Silver Spring, Md.</u>			
DATE SIGNED <u>3-27-56</u>							
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>				934 ELLSWORTH DRIVE, SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>3/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician. The law requires that the death certificate be signed by the attending physician and completed and filed in by the funeral director. After this page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3102
APR 4, 1956
CERTIFICATE OF DEATH

03061

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Dorsey</u> Middle <u>Bussard</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>56</u> (Correct)			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/??/66</u>	
9. AGE (In years last birthday) yrs. <u>89</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>Phillip Myers</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Corn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Right Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>32 days</u> <u>32 days</u> <u>Don't know</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2/2</u> , 19 <u>55</u> , to <u>3/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>55</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>3-7-56</u>							
ACTUAL SIGNATURE <u>JWB</u>				M.D. <u>J. W. Bird, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M.D.</u>				Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Airy, Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-7-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director. After this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

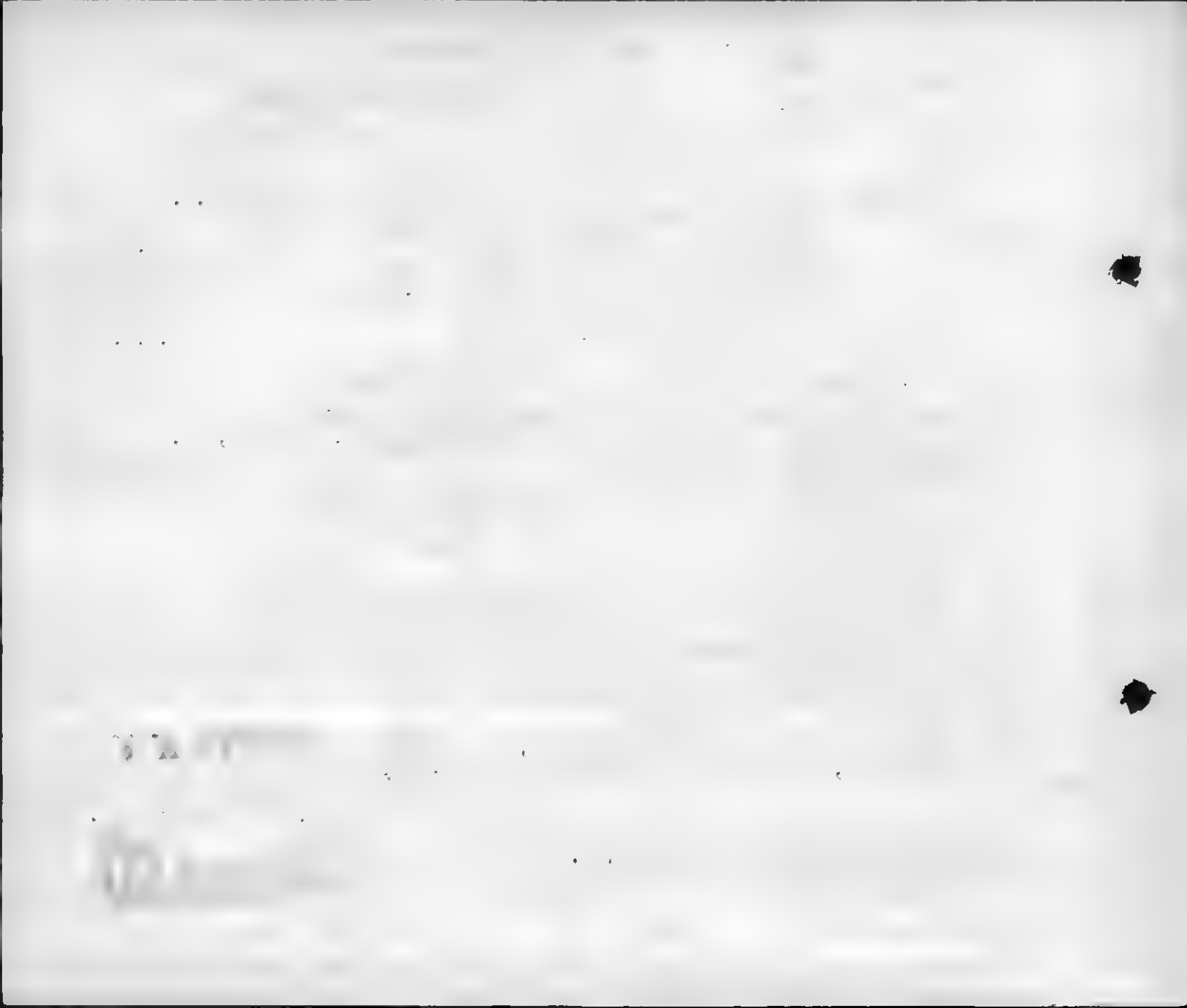
3103

CERTIFICATE OF DEATH

03062

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 2940 Chain Bridge Road, N.W.	
3. NAME OF DECEASED (Type or print) First Howard Middle Barton Last Myers		4. DATE OF DEATH Month March Day 9 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1901
9. AGE (In years (day birthday) yrs.) 55		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		10b. KIND OF BUSINESS OR INDUSTRY Economic Development Iowa	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Barton		14. MOTHER'S MAIDEN NAME Della Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, lung, metastatic DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 20, 1956 , to March 9, 1956 , that I last saw the deceased alive on March 9, 1956 , and that death occurred at 6:18 A.M. from the causes and on the date stated above.			
SIGNATURE Bernard Robert Landau		DATE SIGNED March 9, 1956	
PHYSICIAN'S NAME (Type) Bernard Robert Landau, M.D.		ADDRESS (Street, city or town, state) The Clinical Center, NIH, Bethesda, Md.	
22a. (BURIAL, CREMATION, REMOVAL) (Specify)	22b. DATE THEREOF 3-12-56	22c. NAME OF CEMETERY OR CREMATORY Nat-Mem Park	22d. LOCATION (City, town, or county) (State) Falls Ch. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawlus Sons		24a. REC'D BY REGISTRAR DATE 3-13-56	
ADDRESS 1756 P. Ave. N.W.		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	



3104

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5825 Osceola Road				d. STREET ADDRESS 5825 Osceola Road			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Ruth Last Nave				4. DATE OF DEATH Month March Day 24 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/1905	
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Nave Typograph- ical Co.		11. BIRTHPLACE (State or foreign country) Ruth, Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Augustus Seltz				14. MOTHER'S MAIDEN NAME Rosa Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Ruth A. Simpson - 5108 Baltimore Ave., Washington 16, D.C.				Address			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Branchogenic carcinoma 102A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from July 35 to Mar. 24 56 , that I last saw the deceased alive on Mar 24 56 , and that death occurred at 102A , from the causes and on the date stated above.							
ACTUAL SIGNATURE C P Ryland				M.D. 4400 - 49th St NW			
PHYSICIAN'S NAME (Type) Washington DC				DATE SIGNED 3-24-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Davis Co.				ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 3-27-56	
				24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Providence, R.I.

x

22 Jan 34 20

100A

Office - 4th Ave 2d Flr
New Bedford, Mass

John

22 Jan 34
to 1st of March

x x x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3702

CERTIFICATE OF DEATH

03064

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>16 Belmont Court</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse (none) Newton</u>				4. DATE OF DEATH Month Day Year <u>March 16 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-90</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval gun factory</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jesse Newton</u>				14. MOTHER'S MAIDEN NAME <u>Katie Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Selma R. Newton (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-16</u> , 1956, to <u>3-16</u> , 1956, that I last saw the deceased alive on <u>3-16</u> , 1956, and that death occurred at <u>9:50</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A Hare, M.D.</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. (cleared by Coroner)</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Robert A Hare, M.D.</u>				<u>Takoma Park Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Th. S. H. Hines</u>				ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>3/19/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. H. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03065

3105

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7002 Conn. Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
3. NAME OF DECEASED (Type or print) First <u>WILL</u> Middle <u>D</u> Last <u>NICHOLS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>7</u> Hours <u></u> Min <u></u> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dorothy Nichols, 7002 Conn. Ave. Ch. Ch. and.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4441</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized &</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>20 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture, left femoral neck (12/55), Ulcer duodenum</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <u>Fell on back step of home</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a. m. <u>Nov. 12, 1955</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Chevy Chase, Md.</u>	
21. I certify that I attended the deceased from <u>Nov. 12, 1955</u> , to <u>March 23, 1956</u> , that I last saw the deceased alive on <u>Mar. 22, 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip H. Varner</u> M.D.		ADDRESS (Street, city or town, state) <u>7702 Conn. Ave.</u> DATE SIGNED <u>Mar. 23, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>		<u>Chevy Chase, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

Montgomery Co. Medical Examiner
notified & will approve.

O. A. Warner, M.D.,

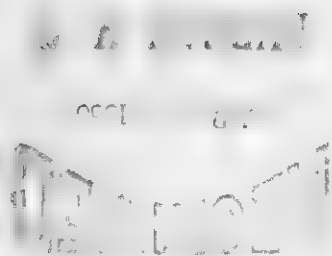
3/23/56

3106
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 273 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bernard Middle Philip Last Nimro Jr.				4. DATE OF DEATH Month March Day 14 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1900		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bernard Nimro				14. MOTHER'S MAIDEN NAME Letitia Witt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		(If yes, give way or date of service) WW # 1		16. SOCIAL SECURITY NO. 577-44-0974		17. INFORMANT The Medical Record, The Clinical Center	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 20 min. 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Mitral Insufficiency							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 15, 1955 , to March 14, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Davidson M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda, Maryland			
PHYSICIAN'S NAME (Type) John Davidson, M. D.				DATE SIGNED 3/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Mar 19, 1956		Arlington National		Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Washington, D.C.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary E. Forrely	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director or attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director should file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

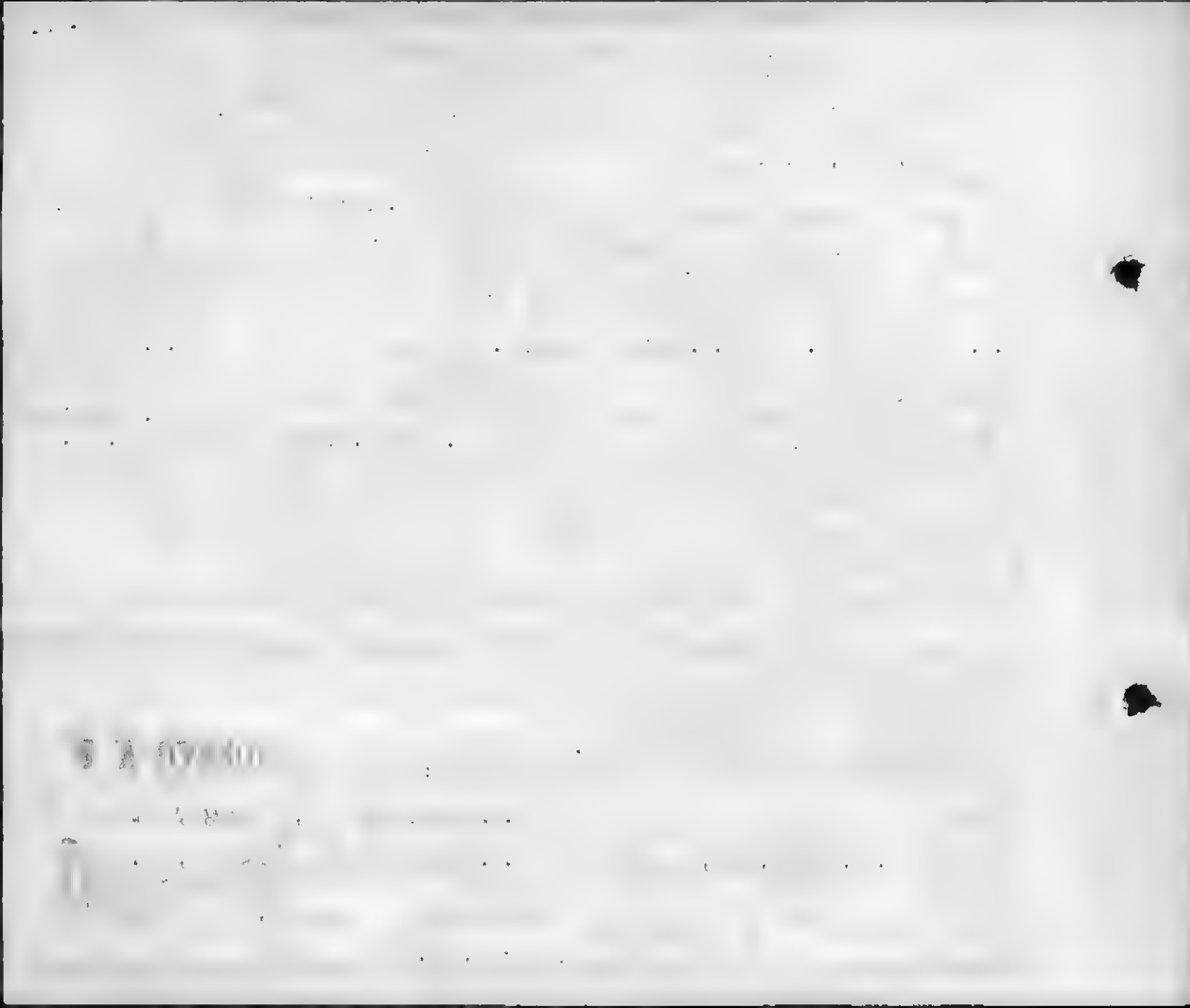


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3127
CERTIFICATE OF DEATH03067
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		c. LENGTH OF STAY IN 1b 23 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
f. STREET ADDRESS 3108 N. Pershing Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Warren Last NORRIS		4. DATE OF DEATH Month march Day 5 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 march 1889
9. AGE (In years last birthday) yrs 66		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) U.S. Marine Corps (Ret.) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME warren NORRIS		14. MOTHER'S MAIDEN NAME Olivia DNUKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I & II		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Wife) Mrs. Mary M. NORRIS		Address 3108 N. Pershing Dr Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARtherosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Feb. 19 56 , to 5 March 19 56 , that I last saw the deceased alive on 5 March 19 56 , and that death occurred at 12:07 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-5-56			
ACTUAL SIGNATURE J. R. Davis M.D.			
PHYSICIAN'S NAME (Type) J. R. DAVIS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7 March 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE E. E. Fitch		24a. REC'D BY REGISTRAR 5 Mar 56 24b. REGISTRAR'S SIGNATURE Mary E. Tarselly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completed. It is to be filed in the file of the deceased. After this certificate has been signed by the attending physician and completed, it is to be filed in the file of the deceased. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it is to be filed in the file of the deceased. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it is to be filed in the file of the deceased. Pages 1 and 2 should be filed with the funeral director.



3108 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10701 Rockville Pike				d. STREET ADDRESS 10701 Rockville Pike			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sister M. Clemenza-Margaret Nugent				4. DATE OF DEATH Month March Day 16 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1889		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Nun		11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nugent				14. MOTHER'S MAIDEN NAME Agnes Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Sisters at St. Angela Hall-Pike, Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis (c) 				INTERVAL BETWEEN ONSET AND DEATH 15 min. 3 hrs Indef			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2/1/56 , to 3/16/56 , that I last saw the deceased alive on 3/16/56 , and that death occurred at 11:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen M. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md.			
PHYSICIAN'S NAME (Type) Stephen M. Jones				DATE SIGNED 3/17/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 3-19-56	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 216

3109

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4914 Sedgwick St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Loehl</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1912</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pension Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Ins. Executive</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Mary Loehl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Anne C. O'Brien, (as Above)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155X</u> DUE TO <u>Adenocarcinoma bile duct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intra-hepatic</u> (c) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> , to <u>3-20-56</u> , that I last saw the deceased alive on <u>3-20-56</u> , 19 <u>56</u> , and that death occurred at <u>5:24</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morton C. Creditor</u>		ADDRESS (Street, city or town, state) <u>Washington Clinic, Wash., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Morton C. Creditor</u>		DATE SIGNED <u>3/20/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Daniels Sons</u>		ADDRESS <u>1756 Pa. Ave. N.W., Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>3-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernard Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
c. LENGTH OF STAY IN 1b 2 YRS. 10 MO.				d. STREET ADDRESS 3615 ORDWAY ST N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUIS First ODDENINO Middle LOUIS Last				4. DATE OF DEATH MARCH 10 1956 Month MARCH Day 10 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-61	
9. AGE (in years last birthday) 94 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY ITALY		11. BIRTHPLACE (State or foreign country) U.S. A.	
13. FATHER'S NAME Joseph Cadenino				14. MOTHER'S MAIDEN NAME CELINA PARACCA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Cedar Haven Rest Home Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 16 weeks years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and Acidosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 9, 1953 to March 10, 1956 ; that I last saw the deceased alive on March 9, 1956 , and that death occurred at 12 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace N. Meek M.D.				ADDRESS (Street, city or town, state) 7701 Carroll Avenue			
PHYSICIAN'S NAME (Type) Wallace N. Meek M.D.				DATE SIGNED Takoma Park 12 Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS 3821-14TH. N.W.		24a. REC'D BY REGISTRAR 3-12-56	
24b. REGISTRAR'S SIGNATURE J. Allen Bell				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ACKNOWLEDGMENTS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3704

CERTIFICATE OF DEATH

Reg. Dist. No.

0302123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Washington D.C.</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				d. STREET ADDRESS <u>301 Hamilton St. NW. Apt. 2</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs Anna</u> First <u>(none)</u> Middle <u>Catrich</u> Last				4. DATE OF DEATH <u>March</u> Month <u>30</u> Day <u>1956</u> Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u> about <u>64</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Taylor, Ralph</u>				14. MOTHER'S MAIDEN NAME <u>Gurwitz, Bessie Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>(if yes, give war or dates of service)</u>		17. INFORMANT <u>patient's chart-</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>March 30</u> 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.</u> M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>A. A. Hillman</u>				ADDRESS (Street, city or town, state) <u>249 Missouri Ave N.W.</u> DATE SIGNED <u>3-30-56</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL A HILLMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Talmud Torah Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Congress Heights D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Son</u>				ADDRESS <u>3501-14th St. NW.</u>		24a. REC'D BY REGISTRAR DATE <u>4/3/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

MEDICAL CERTIFICATION

TO HONORARY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1000

Reg. Dist. No.

DATE _____

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.
PAGE 3 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. R. 1956

1956

1956

3110
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03073
Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>N. Cherry Chase</u>				TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Lane</u>				STREET ADDRESS (If rural, give location) <u>3705 Stewart Dr</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Steven Carl Rayson</u>				<u>3 - 5 - 1956</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>May 12 1953</u>	9. AGE last birthday: <u>2</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas M Rayson</u>				14. MOTHER'S MAIDEN NAME: <u>Elsie Haglund</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Thomas M Rayson (father) same as above</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Asphyxia</u>						<u>for a few days in a small lake</u>	
DUE TO							
Antecedent cause(s) (b) <u>drowning</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>lake</u>)		21c. (City or town) (County) (State) <u>N. Cherry Chase Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-5-56 2 P M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Wandered from home - fell in lake</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-5-56</u>			
M. D. <u>---</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>---</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) (State) <u>District of Columbia</u>	
DATE REC'D BY LOCAL REG <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Martin M. Hyman</u>		ADDRESS <u>1300 N. St. NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

1914

1914

3111
CERTIFICATE OF DEATH

Reg. Dist. No.

03074216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>5 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Alta Vista Rest Home</u>				STREET ADDRESS (If rural give location) <u>5113-13th St. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Jessie GARDNER Reed</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 23, 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 25, 1872</u>	9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker - own home, retired</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
13. FATHER'S NAME: <u>Nerry Ira Gardner</u>				14. MOTHER'S MAIDEN NAME: <u>Nannah J. Win</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Charles D. Reed 5113-13th St. N.W., Washington, D.C.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular DISEASE</u>							<u>YEARS.</u>
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19, 1955</u> , to <u>MAR 23, 1956</u> , that I last saw the deceased alive on <u>MAR 23, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. W. E. ...</u>		ADDRESS <u>M. D. 8025 ABERDEEN RD. Bethesda, Md</u>		DATE SIGNED <u>3/23/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-27-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

W. A. 100

3112

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03025 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Montg</i>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>Rockville - rural</i>		TOWN <i>Rockville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Travilla Rd.</i>		STREET ADDRESS (If rural, give location) <i>Park St.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Clarence</i>	(Middle) <i>Lee</i>	(Last) <i>Reedy</i>	(Month) <i>3</i> (Day) <i>7</i> (Year) <i>1956</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>10-8-39</i>
9. AGE last birthday: <i>18</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>North Harrison Va</i>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Teacher</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>C. P. Reedy</i>		14. MOTHER'S MAIDEN NAME: <i>Jamie E. Hopkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <i>218 34 5704</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Frank B. Hopkins Rockville Md</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Subdural hemorrhage</i>			<i>Immediate death</i>
DUE TO <i>Fracture of skull</i>			
Antecedent cause(s) (b) <i>Fracture of skull</i>			
Diseases or conditions, if any, giving rise to the above cause (c) <i>Fracture of skull</i>			
stating underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Rockville Md</i>	21c. (City or town) (County) (State) <i>Rockville Montg md</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3-4-56 3:51 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>passenger in auto accident</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Frank J. Brockett</i>		M. D. <i>3-4-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>		DATE THEREOF <i>March 7, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Park Lawn</i>		LOCATION (City, town, or county) (State) <i>Rockville Pike Md</i>	
DATE REC'D BY LOCAL REG. <i>3/8/56</i>		24. FUNERAL DIRECTOR <i>Ray W. Barber, Laytonville Md</i>	
REGISTRAR'S SIGNATURE <i>Laurel H. Bradley</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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11 11 11 11 11

GEAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3706

CERTIFICATE OF DEATH

03076

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital 9116 Bradford Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Rhinelander</u> Last <u>Renwick</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21 1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Bronze Co.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William C. Renwick</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Sears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>157-09-5350</u>		17. INFORMANT <u>Mary Renwick</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with left hemiparesis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 6, 1956</u> , to <u>March 27, 1956</u> , that I last saw the deceased alive on <u>March 27, 1956</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR., M.D.</u>				DATE SIGNED <u>March 27, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. RECEIVED BY REGISTRAR <u>7/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edison Dadd</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03077**
No. **2-4**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN KENSINGTON		LENGTH OF STAY (in this place) 22 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN KENSINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,009 FREDERICK AVE.				STREET ADDRESS (If rural, give location) 10,009 FREDERICK AVENUE			
3. NAME OF DECEASED: (Type or Print)		(First) HAROLD		(Middle) JENORAS		(Last) RICHARDSON	
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH: 11/7/96	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Administrator of Taxes		10b. KIND OF BUSINESS OR INDUSTRY: Assessors Office		9. AGE last birthday: 59 yrs.		4. DATE OF DEATH (Month) MARCH (Day) 16 (Year) 19 56	
11. BIRTHPLACE (State or foreign country): STATE LINE, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: HAROLD RICHARDSON				14. MOTHER'S MAIDEN NAME: JENORA STONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: MRS. EVELYN B. RICHARDSON, 10009 FREDERICK AVE KENSINGTON, MARYLAND			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Coronary occlusion DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE Frank J. Bruchant		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED 3-17-57	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 3/19/56		NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		LOCATION (City, town, or county) (State) Montgomery County, Md.	
DATE REC'D BY LOCAL REG 3-19-56		REGISTRAR'S SIGNATURE Francis C. Carter		24. FUNERAL DIRECTOR Wm. H. Lamphrey		ADDRESS Silver Spring, Maryland	

U. S.

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete this certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3021

CERTIFICATE OF DEATH

03078

Reg. Dist. No. 213

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) 12201 Rockville Pike				d. STREET ADDRESS 4409 Maple Avenue			
3. NAME OF DECEASED (Type or print) First W. Middle T. S. Last RIDDLE				4. DATE OF DEATH Month March Day 5 Year 19 56			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1865	
9. AGE (In years last birthday) yrs 90		IF UNDER 1 YEAR Months 4 Days 20 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Owner Self-employed	
11. BIRTHPLACE (State or foreign country) Kentucky				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James W. Riddle				14. MOTHER'S MAIDEN NAME Mary Jane Hunt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT William Blankenship Address 4409 Maple Ave. Bethesda Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO 332X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis & Cardiac Failure DUE TO 3 day							
(c) Just arteriosclerosis DUE TO Indef.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/22/1955 , to 3/5/1956 , that I last saw the deceased alive on 3/4/56 , 19 56 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 3/5/56			
PHYSICIAN'S NAME (Type) Stephen N. Jones M.D.				LOCATION (City, town, or county) Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-56		22c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		22d. LOCATION (City, town, or county) (State) Lynchburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 3/7/56		24b. REGISTRAR'S SIGNATURE Laurel H. Kaylor	

8.12.

ALBERT A. J.



1914

L. A. DUNN

1910

3908

CERTIFICATE OF DEATH

03080
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE <u>Washington D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>1511 M. SE.</u>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Ritter</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 25, 1881</u>	9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months Days Hours M n		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Kilcomins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wamsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. S.P. Phillips</u> Address <u>6 LAUREL TERRACE S.S.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive retroperitoneal hemorrhage</u> (c) <u>Rupture arteriosclerotic aneurysm of abdominal aorta</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Generalized Arterio-sclerosis 2) Arterial Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year How <u>a.m.</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 22, 1956</u> to <u>Mar 27, 1956</u> that I last saw the deceased alive on <u>Mar 26, 1956</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>7835 Eastern Ave Mar 27</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				DATE SIGNED <u>Silver Spring Md 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anselm</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Smattingly</u>				ADDRESS <u>1311 1st St. S.E. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>3/27/56</u>				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

MEDICAL CERTIFICATION

TO THE SURGEON OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 215

3114

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 424 North Nelson Street			
3. NAME OF DECEASED (Type or print) First Florence Middle Clayton Last ROSSELL				4. DATE OF DEATH Month March Day 22 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-82	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Louis CLAYTON				14. MOTHER'S MAIDEN NAME Ema H. DASHIELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband Joseph A. ROSSELL Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 14 Mar 19 56 to 22 Mar 19 56 , that I last saw the deceased alive on 22 Mar 19 56 , and that death occurred at 6:34 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda, Maryland DATE SIGNED ACTUAL SIGNATURE H. A. Schlang M.D. PHYSICIAN'S NAME (Type) H. A. SCHLANG LCDR, MC, USN USNH, NNMC, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 Mar 56		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Sutphin Ives Funeral Home 2847 Wilson Blvd Arlington, Va.				24a. REC'D BY REGISTRAR DATE 23 Mar 56		24b. REGISTRAR'S SIGNATURE Harry E. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13 14 15

1956 2 10



3709

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>22 days</u>		d. STREET ADDRESS <u>10332 Parkman Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mary</u> Last <u>Rutherford</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-87</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Jones</u>		14. MOTHER'S MAIDEN NAME <u>Amy Seavers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chloroform asphyxia of Colon</u> <u>153X</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18, 1955</u> to <u>March 18, 1956</u> that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1200 Lebanon St Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>Boris Rabkin M.D.</u>		DATE SIGNED <u>3-18-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>21 MARCH 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nelson's Funeral Home</u>		ADDRESS <u>3000 R.I. Ave. Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>3/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3115

CERTIFICATE OF DEATH

Reg. Dist. No.

03083

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 133 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 1800 S Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle May Last Sanders		4. DATE OF DEATH Month March Day 6 Year 1956			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1903	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Edward Grant		14. MOTHER'S MAIDEN NAME Martha Savoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST WITH METASTASES TO BONE 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 110X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH --
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NONE			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	
20f. (City or town) NONE		20g. (County) NONE		20h. (State) NONE	
21. I certify that I attended the deceased from October 25, 1955 to March 6, 1956 , that I last saw the deceased alive on March 6, 1956 , and that death occurred at 8:43 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Horace Herbsman		ADDRESS (Street, city or town, state) The Clinical Center, NIH, Bethesda, Md. DATE SIGNED 3/2/56			
PHYSICIAN'S NAME (Type) Horace Herbsman, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.12.56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	
22d. LOCATION (City, town, or county) Arlington, Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. McQuinn		ADDRESS 1820-9th St., N. W.		24a. REC'D BY REGISTRAR DATE 3-9-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson					

Figure 1

3710

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs. 9 mos.</u>		d. STREET ADDRESS <u>Falkstone Ct., 14th Fairmont Stnd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Seniors Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Mae</u> Last <u>Sunbury</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-71</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Schotta</u>		14. MOTHER'S MAIDEN NAME <u>Emma Platt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Washington Seniors Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2X Congestive Cardiac Failure</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Three days</u> <u>Four years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>3-24-1956</u> ; that I last saw the deceased alive on <u>3-23-1956</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert A HARE</u>		DATE SIGNED <u>3/24/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co</u>		ADDRESS <u>2901-14th St. N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>3/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31

100

7000-10000

3011

03085
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Mon</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Takoma Park</u>				TOWN <u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1901 LAUREL RD</u>				STREET ADDRESS <u>1210 Jackson Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Dominico</u> <u>Scopelliti</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>5</u> <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 4, 1907</u>	9. AGE last birthday: <u>48</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Garner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Garner</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Scopelliti</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Marie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>No</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mary C. Scopelliti, 121 Jackson Ave T.P. Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>420.1</u> Immediate cause (a) ... <u>Coronary occlusion</u> ... DUE TO Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		<u>peritonitis</u>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Franz J. Brochert M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 3-5-56
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>	DATE THEREOF: <u>March 3 1956</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Michael's</u>	LOCATION (City, town, or county) (State): <u>Hyattsville - Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>3-5-56</u>	REGISTRAR'S SIGNATURE: <u>William D. B.</u>	24. FUNERAL DIRECTOR: <u>Walter H. Hatter</u>	ADDRESS: <u>254 Carroll St - D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-10-11

MAR 7 1938

11-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086

3116

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery Bethesda, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 1420 12th Drive, Yuma, Arizona			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Yuma, Yuma, Arizona			
d. NAME OF HOSPITAL (If not in hospital, give street address) National Institutes of Health				d. STREET ADDRESS 1420-12th. Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jack - First Keating Sentz - Last				4. DATE OF DEATH March 25 Month Day Year 1956			
5. SEX Male	6. COLOR OF RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 June 1917		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Mich		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Sentz				14. MOTHER'S MAIDEN NAME Margaret Keating			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 370-14-8518		17. INFORMANT Patient's admission record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease with mitral stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary congestion						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1956 to March 25, 1956 , that I last saw the deceased alive on March 25, 1956 , and that death occurred at 5:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clinical Center Bethesda, Maryland DATE SIGNED March 25, 1956							
ACTUAL SIGNATURE George C. Kaiser M.D.		PHYSICIAN'S NAME (Type) George C. Kaiser, M.D.					
22a. BURIAL CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3-26-56		22c. NAME OF CEMETERY OR CREMATORY Desertlawn Mem. Park		22d. LOCATION (City, town, or county) (State) Yuma Co, Arizona	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 3-28-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED V. S.

MAR 10 1930

150-1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03087 Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Blount</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Kensington</u>		LENGTH OF STAY (in this place) <u>3 1/2 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9209 Kensington Blvd</u>				STREET ADDRESS (If rural, give location) <u>9209 Ken. Blvd.</u>			
3. NAME OF DECEASED: (First) <u>Katherine Elliott</u> (Middle) <u>Skinner</u> (Last) <u>Skinner</u>				4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX: <u>fe</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Sept 19 - 89</u>	9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>W. J. Elliott</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Chadlock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>4802 Hlanders Ave</u> <u>Doris Matthews Kensington Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause			(a) <u>Cerebral Vascular Accident</u>				<u>2 days</u>
			DUE TO				
Antecedent cause(s)			(b) <u>Hypertension</u>				<u>5 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			DUE TO				
			(c)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple Myeloma</u>							<u>3 yrs</u>
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Brothman</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-20-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>Shenwood Cem.</u>		LOCATION (City, town or county) (State) <u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REG. <u>3-20-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>St. Johns Co.</u>		ADDRESS <u>2901 14th St NW Wash. D.C.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3118

CERTIFICATE OF DEATH

03088

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> Rt # <u>3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Box 620</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Virginia</u> Last <u>Shields</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26 1900</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Lear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>John Henry Shields</u> Address <u>Box 620 Bethesda Md.</u>	
17. INFORMANT <u>John Henry Shields</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
DUE TO (b) <u>Hypertensive Heart Disease</u>		DUE TO (c) <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rt (Pneumo-pyr-thorax)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>4</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Mar. 10 56</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 10 56</u> , to <u>Mar. 10 56</u> , that I last saw the deceased alive on <u>Mar. 10 56</u> , and that death occurred at <u>Mar. 10 56</u> , M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>104 Cherry Chase Rd. 3/11/56</u> DATE SIGNED <u>George A. Gray, Jr. M.D.</u>	
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u>		PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr. M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF DEATH <u>3/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Hurdon</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Beattie M. Thompson</u> 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

MAR 16 1964

3119

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Montgomery County General Hosp. Inc</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Shipley</u> Last <u>Shipley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/18/74</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Oliver C. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>July</u> , 1948, to <u>March 17</u> , 1956, that I last saw the deceased alive on <u>March 16</u> , 1956, and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>3/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>HOWARD CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Clarksville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude B. Lawler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03090

3120

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		e. STREET ADDRESS 1300 Massachusetts Ave., N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Estella Rebecca Shipp		4. DATE OF DEATH Month Day Year March 22, 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1920
9. AGE (In years birthday) yn. 35		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Girl		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harrison L. Shipp		14. MOTHER'S MAIDEN NAME Cora Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. Not avail.	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MI 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral ventricular abn. + Pyonephrosis DUE TO (c) Recent basilar pneumonia			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19, 1956 , to March 22, 1956 , that I last saw the deceased alive on March 22, 1956 , and that death occurred at 2:52 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard R. Paton		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Richard R. Paton, M. D.		National Institutes of Health Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-56	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Schley		ADDRESS Wash. DC	
24a. REC'D BY REGISTRAR 3-23-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

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1950

1950

3121

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		c. LENGTH OF STAY IN 1b 20 Minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4316 Burns St., S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, BETHESDA, MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Olga Last SLYE		4. DATE OF DEATH Month March Day 18 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 1888
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Frances GEORGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Walter C. SLYE, 4316 Burns St. S.E.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 423.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours Indefinite	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 March 1956 to 18 March 1956 that I last saw the deceased alive on 18 March 1956 , and that death occurred at 5:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter L. Blankenbaker		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-18-56	
PHYSICIAN'S NAME (Type) WALTER L. BLANKENBAKER, LTJG, MC, U.S. Naval Hospital, Bethesda, Md.		USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 19 March 1956	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR J.W. Lee		24b. REGISTRAR'S SIGNATURE Mary E. Gansley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3122

CERTIFICATE OF DEATH

Reg. Dist. No.

218

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Logansport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shenandoah</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harace Clinton Smith</u>		4. DATE OF DEATH Month Day Year <u>Mar 18 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 3-1916</u>
9. AGE (In years last birthday) <u>39</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Logansport, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Livingston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-5371</u>	
17. INFORMANT <u>Mary F. Smith</u> Address <u>Germanstown, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Anemia</u> DUE TO (c) <u>Acute Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16</u> , 19 <u>56</u> , to <u>3/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>56</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lucius L. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Lucius L. Leal</u>		<u>112 N. Frederick Ave. Smithsburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Yellow Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Yellow Creek, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart's Funeral Home, Covert Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Mar 21/56</u> 24b. REGISTRAR'S SIGNATURE <u>Libbe Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 X 11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3123

CERTIFICATE OF DEATH

03093

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>N. Y.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IRMA OLNEY MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>151 TORALEMON ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROOKE GROVE MD HOSP</u>		d. STREET ADDRESS <u>OLNEY MD</u>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>C</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>31</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 29 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1.3 M. OPERATOR</u>	
11. BIRTHPLACE (State or foreign country) <u>BROOKLYN N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS HENRY SMITH</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN GRIGGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>132-036882</u>	
17. INFORMANT <u>THOMAS L. SMITH</u>		Address <u>SILVER SPRING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion - Thrombosis</u> DUE TO <u>Diabetes Mellitus - Ren.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>arteriosclerosis + Ca of Prostate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>20 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>23 May 1955</u> to <u>31 March 1956</u> , that I last saw the deceased alive on <u>30 March 1956</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Boskey Ziegler</u> M.D.		DATE SIGNED <u>31 March 56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 3 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PINE LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>SUFFOLK CO NY YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W BAREER</u> ADDRESS <u>LAYTONSVILLE</u>		24a. REC'D BY REGISTRAR <u>31-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bertrude B Lawler</u>

TO REGISTER OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3012 CERTIFICATE OF DEATH

03094

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		LENGTH OF STAY (In this place) May 7, 1953		CITY (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		TOWN WASHINGTON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 ALBANY AVENUE GEN. HATCH Conv. Home				STREET ADDRESS (If rural give location) BELLEVUE HOTEL 15 E STREET, N.W.			
3. NAME OF DECEASED (Type or Print) LAURA F STALNAKER				4. DATE OF DEATH (Month) 3 (Day) 4 (Year) 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH OCT. 29, 1859	9. AGE (last birthday) 96 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) OAKLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ISAAC WHITE STALNAKER				14. MOTHER'S MAIDEN NAME HARRIET TALBOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS DR. ELIZABETH STALNAKER, MORGANTOWN, W. VA.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						many years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/28/45, 19 to 3-3-56, 1956, that I last saw the deceased alive on 2/23, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above.							
SIGNATURE E. L. B. Carr		M.D. 15 E St. N.W. Washington D.C. 3/4/56		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 3/8/56		NAME OF CEMETERY OR CREMATORY BLUEMONT CEMETERY		LOCATION (City, town, or county) GRAFTON, TAYLOR COUNTY, W. VA.	
24. REC'D BY REGISTRAR DATE 3-7-56		REGISTRAR'S SIGNATURE J. Walter Bell		25. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pumphrey		ADDRESS 8434 Georgia Ave. Silver Spring, Md.	

UNITED STATES

21 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1. File No. 3124 CERTIFICATE OF DEATH

03095

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>10 hours</u>		d. STREET ADDRESS <u>4309 Stanford St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Mary Stevens</u>		4. DATE OF DEATH Month Day Year <u>March 30 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sheckels</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Sheckles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Son. Jackson Stevens - above</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>acute pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardiovascular disease</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① acute bronchitis ② arteriosclerosis generalized ③ arteriosclerotic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart Disease</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>49</u> , to <u>Present</u> 3/30/56, that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Coale</u>		ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		DATE SIGNED <u>March 31, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/3/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSOING COMPANY</u>		ADDRESS <u>1300 N. STREET, N.W.</u>	24a. REC'D BY REGISTRAR <u>DATE 4-2-56</u>
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

APR 4 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03096

3125 CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>SILVER SPRING</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SILVER SPRING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 SCHUYLER RD</u>				STREET ADDRESS (If rural give location) <u>517 SCHUYLER RD.</u>			
3. NAME OF DECEASED: (First) <u>ALEX</u> (Middle) <u>M.</u> (Last) <u>STEWART</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAR. 17</u> 19 <u>56</u> .			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>APRIL 4, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>C.T. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>WESTVILLE, PICTOE, N.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>WILLIAM STEWART</u>				14. MOTHER'S MAIDEN NAME: <u>MAC DONALD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>162-12-1889</u>		17. INFORMANT & ADDRESS: <u>MRS MARARET S. DINGER 507 SCHUYLER RD. SILVER SPRING, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE (S) <u>Generalized Arterio Sclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Pneumonia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>any</u> , 19 <u>54</u> , to <u>March 17, 1956</u> that I last saw the deceased alive on <u>March 13, 1956</u> , and that death occurred at <u>11:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. W. Cross</u>		ADDRESS <u>8248 Regalia Rd. Silver Spring, Md.</u>		DATE SIGNED <u>March 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Morningside Cemetery</u>		LOCATION (City, town, or county) (State) <u>La Bais, Charles Co., Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-19-56</u>		REGISTRAR'S SIGNATURE <u>Frances [illegible]</u>		24. FUNERAL DIRECTOR <u>Sharon [illegible]</u>		ADDRESS <u>254 Carroll St. N.W. Tibora Park, D.C.</u>	

JOHN V. S.

MAR

1900

CERTIFICATE OF DEATH

24

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

U. S.

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1941

3127

CERTIFICATE OF DEATH

Reg. Dist. No. 03098

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 yr. 11 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM				d. STREET ADDRESS 1630 Castleton Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Cornelius Middle Joseph Last SULLIVAN		4. DATE OF DEATH		Month March Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY Mariner (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Dennis S. SULLIVAN				14. MOTHER'S MAIDEN NAME Barbara O'SULLIVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO WW-II		17. INFORMANT Mr. Dennis SULLIVAN, 1630 Castleton Ave.,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) amyotrophic lateral sclerosis DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 April 1954 to 27 March 1956 , that I last saw the deceased alive on 27 March 1956 , and that death occurred at 5:16 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Le Roy E. Kurth M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) Le Roy E. KURTH, LT. MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 29 March 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY				ADDRESS Bethesda, Md. 1557 Wisconsin Ave.,		24a. REC'D BY REGISTRAR DATE 3-27-56	
				24b. REGISTRAR'S SIGNATURE Mary E. Carroll			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

U. S. DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3013

CERTIFICATE OF DEATH

03099

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>1523 East Fiskland Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Francis</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOT EL MANAGER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>7100000000</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Alice Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterio-sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year 4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>54</u> , to <u>Mar 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 22</u> , 19 <u>56</u> , and that death occurred at <u>11:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u>		DATE SIGNED <u>Mar 23 1956</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>3/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold P. Humphrey 4/3/56</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 3/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 1 1964
U. S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3128

CERTIFICATE OF DEATH

Reg. Dist. No. 031008

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) 105 GROVE STREET		d. STREET ADDRESS 105 GROVE STREET	
3. NAME OF DECEASED (Type or print) WILLIAM TAYLOR TEEPE		4. DATE OF DEATH MARCH 11 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 26, 1880
9. AGE (in years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) CHIEF CLERK, PROCUREMENT DIV., U.S. GOV'T.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM HENRY TEEPE		14. MOTHER'S MAIDEN NAME ELIZABETH ANN GREER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. BLANCHE K. TEEPE, 105 GROVE ST., WASHINGTON		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Lung - metastatic - 177X DUE TO metastatic - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Prostate Gland DUE TO Gland (c) Gland	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 months 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5th , 19 56 , to Mar. 11 , 19 56 , that I last saw the deceased alive on Mar. 10 , 19 56 , and that death occurred at 7:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher		DATE SIGNED 3-11-56	
PHYSICIAN'S NAME (Type) Jack Schumacher			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Boxner E. Humphrey		24a. REC'D BY REGISTRAR DATE Mar. 13-56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Wanda L. Lorde	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1556

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>7 Wks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparksville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>Rt. #2</i>	
3. NAME OF DECEASED (Type or print) <i>James Luther Thompson</i>		First Middle Last		4. DATE OF DEATH Month Day Year <i>3 1 1956</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>6-7-87</i>		9. AGE (In years last birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Cleaner</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Alfred Thompson</i>		14. MOTHER'S MAIDEN NAME <i>MARY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-10-8400</i>		17. INFORMANT <i>Walter C Thompson - Son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO <i>adenocarcinoma, metastatic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Biliary Obstruction, Bladder</i> DUE TO <i>AZOTEMIA</i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <i>1-16-</i> 19 <i>56</i> , to <i>3-1-</i> 19 <i>56</i> , that I last saw the deceased alive on <i>3-1-56</i> , at <i>12</i> P.M., and that death occurred at <i>8</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Sparksville, Md.</i> DATE SIGNED <i>(Attending)</i>					
ACTUAL SIGNATURE <i>Linwood H. Johnson</i> - M.D.					
PHYSICIAN'S NAME (Type) <i>LINWOOD H. JOHNSON VR.</i> Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-5-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>EBERHARDEZ</i>	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Hicks</i>		ADDRESS <i>Fred, Md.</i>		24a. REC'D BY REGISTRAR <i>Mar. 6, 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Walter C Thompson</i>					

JOHN A. V. 2

MAR 2

1951

3714 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>MONT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TAKOMA PARK.</u>		<u>5 yrs.</u>		TOWN <u>TAKOMA PARK.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>OAKHAVEN CONVA. HOME</u>				STREET ADDRESS (If rural give location) <u>517 ALBANY AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>LOUISA GREEN THOMPSON</u>				<u>MARCH 1 1956</u>			
5. SEX: <u>FE</u>		6. COLOR OR RACE: <u>WH.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WID.</u>		8. DATE OF BIRTH: <u>JUNE 5, 1860</u>	
9. AGE last birthday: <u>95</u> yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>Hswt.</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>THOMAS MARSHALL</u>				14. MOTHER'S MAIDEN NAME: <u>HENRIETTA LYLES.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.: <u>-</u>		17. INFORMANT & ADDRESS: <u>Records: Oakhaven.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Bronchopneumonia, bilateral</u>		<u>4 days.</u>
DUE TO		
Antecedent causes (s) (b) <u>-</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		years.
Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, generalized, severe.</u>		
19a. DATE OF OPERATION: <u>None</u>	19b. MAJOR FINDINGS OF OPERATION: <u>-</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) <u>NO</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>-</u>	(CITY OR TOWN) <u>-</u>	(COUNTY) <u>-</u>	(STATE) <u>-</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>-</u>		

22. I hereby certify that I attended the deceased from Feb 28, 1956, to Mar 1, 1956, that I last saw the deceased alive on Mar 1, 1956, and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE <u>William J. Simpson, M.D.</u>		ADDRESS <u>6216 N.H. Ave N.E.</u>		DATE SIGNED <u>3/1/56.</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/5/56</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Mar 4 1956</u>	REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3130

CERTIFICATE OF DEATH

03103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE Maryland c. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville				c. LENGTH OF STAY in 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 240				d. STREET ADDRESS Rt. 240			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES P. B. VEIRS				4. DATE OF DEATH Month Day Year Mch 7, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-6-65	9. AGE (In years last birthday) yrs. 90	IF UNDER 1 YEAR Months Days 11 1	IF UNDER 24 HRS Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming-Owner		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William A. Veirs				
14. MOTHER'S MAIDEN NAME Rebecca Thomas Biays			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT Address Julian M. Whiting-Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 332X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Cerebral Thrombosis (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 hrs 1 week Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that I attended the deceased from <u>June 1, 1953</u> , to <u>3/7/56</u> , that I last saw the deceased alive on <u>3/7/56</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.			ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>		DATE SIGNED <u>3/8/56</u>		
PHYSICIAN'S NAME (Type) Stephen N. Jones			Rockville, Maryland		3/8/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-56		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3/9/56		
					24b. REGISTRAR'S SIGNATURE <u>Laurel H. Kraybill</u>		

188-10

10

10. 24. 10. 10. 10. 10.

3131

CERTIFICATE OF DEATH

03104

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4001 Pipers</u>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>-ee-</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-87</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Wines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8929</u>		17. INFORMANT <u>Catherine Bible</u> Address <u>10605 Drum Ave. Kensington Md</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mths. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Feb. 16, 1956</u> to <u>May 24, 1956</u> that I last saw the deceased alive on <u>May 24, 1956</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>104 Chevy Chase Drive N.W. Wash. D.C.</u> DATE SIGNED <u>3/24/56</u>			
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>George A. GRAY, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22c. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>8-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3132

CERTIFICATE OF DEATH

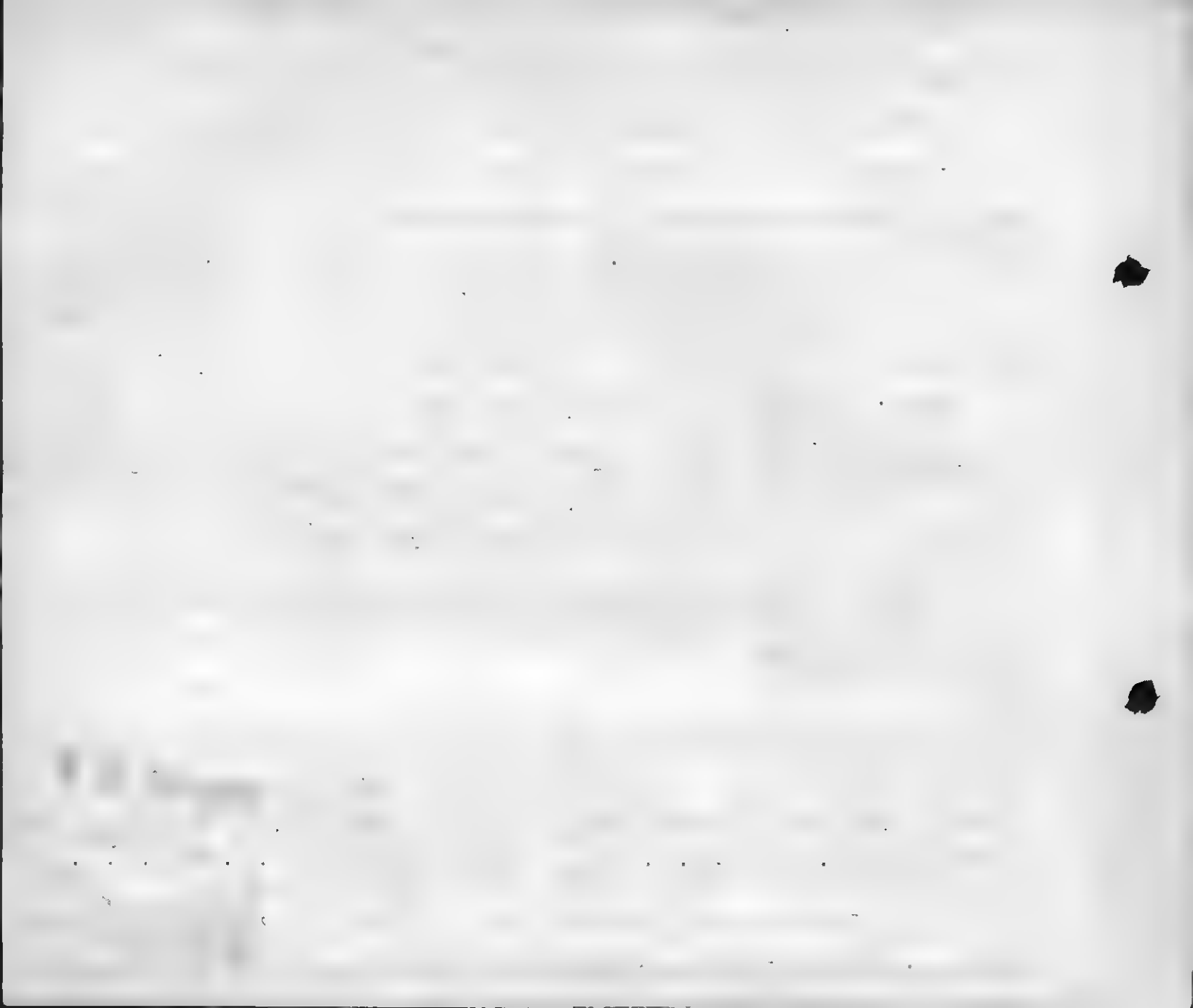
03105

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3311 Winnett Road</u>		d. STREET ADDRESS <u>3311 Winnett Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERTA G. WALLACE</u>		4. DATE OF DEATH Month Day Year <u>March 14, 1956</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/97</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maine</u>
13. FATHER'S NAME <u>James M. Greaney</u>		14. MOTHER'S MAIDEN NAME <u>Emma Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>William Wallace-Item# 2</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/29, 1956</u> to <u>3/14, 1956</u> , that I last saw the deceased alive on <u>3/14/56</u> , 19 <u>56</u> , and that death occurred at <u>7:53 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D.		ADDRESS (Street, city or town, state) <u>113 Carroll St NW, Wash DC</u> DATE SIGNED <u>3/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Dean H. Harding, M.D.</u>		<u>113 Carroll Street, N. W., Wash. D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>3-16-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03106
Reg. Dist.

No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Gaithersburg - R-1</u>		LENGTH OF STAY (in, this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Gaithersburg R-1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Emory Grove</u>				STREET ADDRESS (If rural, give location) <u>Emory Grove</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Stephen Audri Waters</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 27 1956</u>			
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>cal</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>2-9-56</u>	
9. AGE last birthday: yrs. <u>18</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>	
13. FATHER'S NAME: <u>Irving Finger</u>				14. MOTHER'S MAIDEN NAME: <u>Glenn Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Glenn Waters (mother) same as Glenn 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH <u>life</u>	
Immediate cause (a) <u>Congenital heart disease</u> DUE TO							
Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>—</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Broshant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-27-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/30/56</u>		<u>Emory Grove</u>		<u>Emory Grove, md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Mar 31, 56</u>		<u>Robert L. Snodden</u>		<u>Robert L. Snodden - Rockville, md.</u>			

10

2-27-74

473

42

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3015

CERTIFICATE OF DEATH

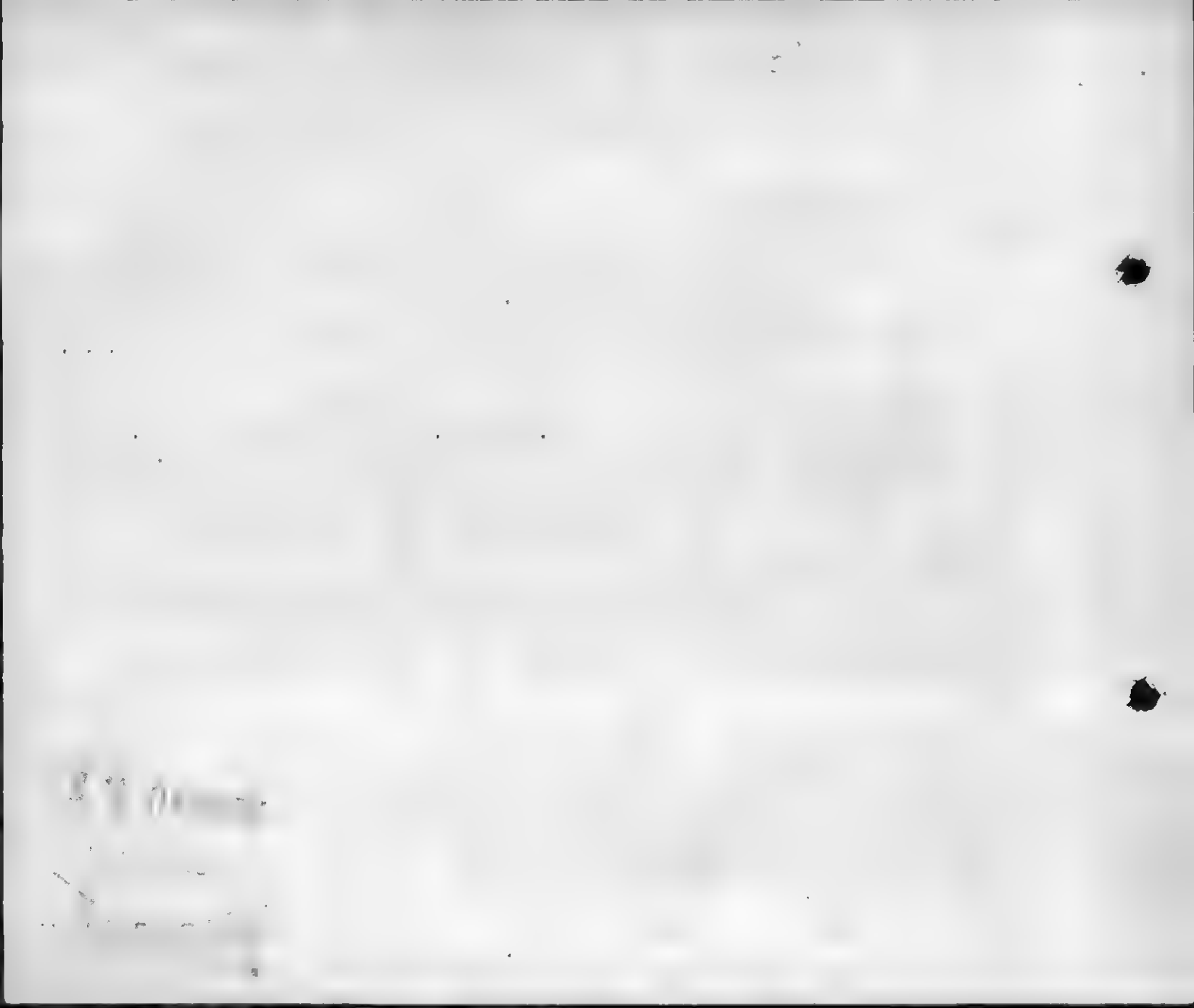
Reg. Dist. No.

03107
223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1110 LANCASTER ROAD		d. STREET ADDRESS 1110 LANCASTER ROAD	
3. NAME OF DECEASED (Type or print) EDITH		4. DATE OF DEATH Month MARCH Day 30 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25, 1947
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 30 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolgirl		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PORT ARTHUR, TEXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES EDWARD WEBER		14. MOTHER'S MAIDEN NAME DOROTHY MORELAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. James E. Weber, 1110 Lancaster Rd. Takoma Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic fibrosis of the pancreas DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 9 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15 , 1956 , to 3-30 , 1956 , that I last saw the deceased alive on 3-30-56 , 19 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4105 Wisconsin Ave, NW, Washington D.C. DATE SIGNED			
ACTUAL SIGNATURE George J. Cardany M.D.		PHYSICIAN'S NAME (Type) George J. Cardany	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/2/56	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/31/56	
24b. REGISTRAR'S SIGNATURE F. William Dodd			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3134

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Dist. Of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY IN 1b 1 1/2 yrs.		d. STREET ADDRESS 5611-New Hamp.Ave.N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle L. Last WEEKLEY		4. DATE OF DEATH Month MARCH Day 4 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1880
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR: Months 9 Days 17 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME XXXXXXXX Bingley ; Joseph		14. MOTHER'S MAIDEN NAME XXXXXXXX Eliza Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Wm. D. Mr. XXXXX Weekley		Address (Husband) 5611-New Hamp.Ave.NW Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs + 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 23 , 19 53 , to Mar 4 , 19 56 , that I last saw the deceased alive on March 3 , 19 56 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Harnsberger M.D.		DATE SIGNED 3/4/56	
PHYSICIAN'S NAME (Type) CHAS. W. HARNBERGER		4201 NEW HAMPSHIRE AVE. N.W. WASH. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/6/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson		24a. REC'D BY REGISTRAR 3/6/56	
ADDRESS 1500-N ST N.W.		24b. REGISTRAR'S SIGNATURE Charles Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

03109

3135

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> TOWN <u>Spencerville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>5 weeks</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Orange</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Grace</u> (Middle) <u>Elizabeth</u> (Last) <u>Williams.</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>12/22/1887</u>		9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13. FATHER'S NAME <u>William H. Stackhouse</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Butty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Luther J. Williams - Spencerville, Md</u>		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Starvation</u> Immediate cause (a) <u>Cicatricial Contraction Esophagus</u> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Drank lye at 4 years of age Sustained on liquids until complete obstruction occurred</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>years</u>	
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
11a. DATE OF OPERATION		11b. MAJOR FINDINGS OF OPERATION		12. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/18</u> , 195 <u>6</u> , to <u>3/21</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>3/15</u> , 195 <u>6</u> , and that death occurred at <u>6:15 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>J.M.R. 1</u>		(Degree or title)		ADDRESS <u>Sandy Spring, Maryland</u> DATE SIGNED	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Union-Burtonsville, Md</u> LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>3-22-56</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>		24. FUNERAL DIRECTOR <u>De Witt Donaldson - Laurel, Md</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

72.571

100-1

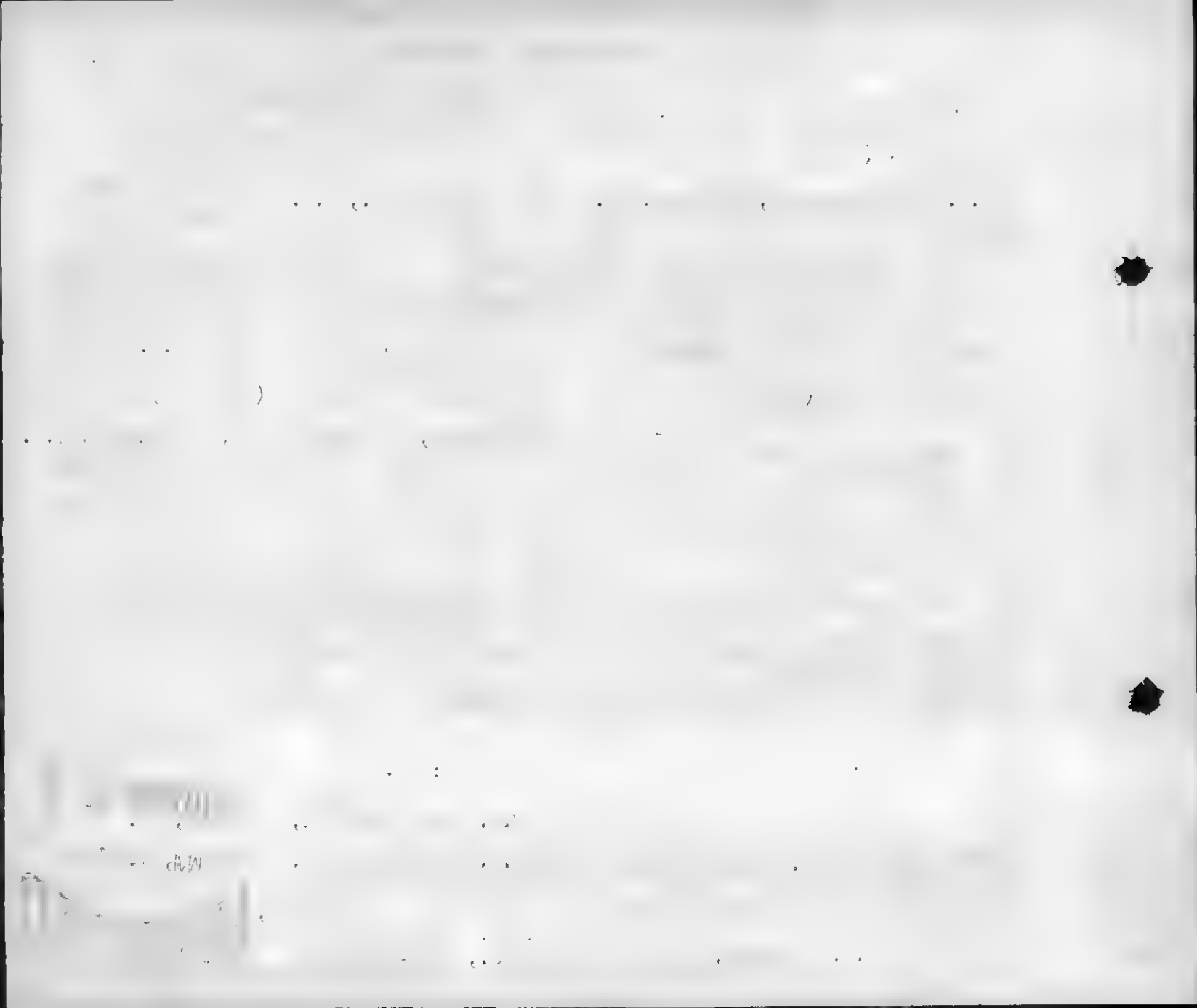
3136

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1746 Q St., N.W.			
3. NAME OF DECEASED (Type or print) First Helen Middle Ames Last WILLIAMS				4. DATE OF DEATH Month March Day 21 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 April 1873	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Nathaniel Ames (Deceased)				14. MOTHER'S MAIDEN NAME Elizabeth Mc Donald (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Thomas Sandoz, 2 DuPont Circle, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Left Ventricle 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction DUE TO (c) Atherosclerotic Coronary Artery Disease						INTERVAL BETWEEN ONSET AND DEATH 2 min 5 min unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 March , 19 56 , to 21 March , 19 56 , that I last saw the deceased alive on 21 March , 19 56 , and that death occurred at 11:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard G. Fosburg, M.D. U.S. Naval Hospital, Bethesda, Md. 3-22-56							
ACTUAL SIGNATURE Richard G. Fosburg M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) Richard G. Fosburg, LTJG, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 March 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMFREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-21-56	
				24b. REGISTRAR'S SIGNATURE Frank E. Passelty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



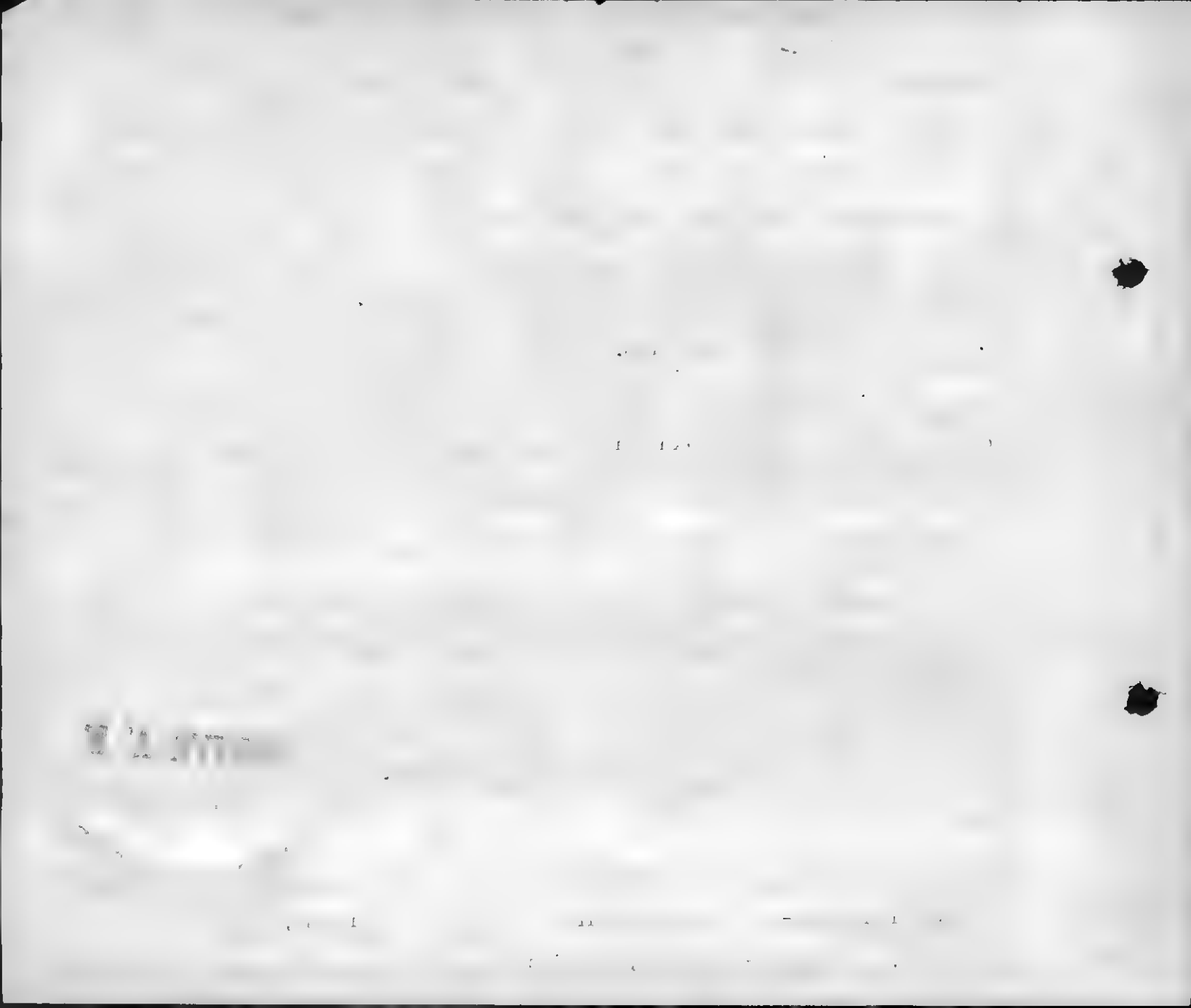
3137

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>9131 Jones Mill Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernhard</u> Middle <u>Winkler</u> Last <u>Winkler</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernhard Winkler</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Son, Fred B. Winkler</u>		Address <u>8728 Suzanna Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, Terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis, bilateral</u> DUE TO (c) <u>Arterio-sclerosis, generalised</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary in foci left Lung. Bronchopneumonia rt. lung</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ 19 _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		20g. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1952</u> , to <u>March 22, 1956</u> , that I last saw the deceased alive on <u>3-21</u> , 19 <u>56</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar Sp. Co. Wash DC</u> DATE SIGNED <u>3-22-56</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar Sp. Co. Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>3-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>8-26-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 223

3916

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Colorado</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grand Junction</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>943 Rood Ave Apt. 6.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMY CATHERINE WOLFE</u>		4. DATE OF DEATH Month Day Year <u>March 22 1956</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HS. Wk.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Sheets</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Croff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 14, 1956</u> to <u>Mar 22, 1956</u> that I last saw the deceased alive on <u>Mar 22, 1956</u> , and that death occurred at <u>8:30 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carver Ave., Takoma Park</u>	
PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAR 28, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>GRAND JUNCTION, COLO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Kelly</u> ADDRESS <u>254 Carroll St NW D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>3/26/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. P. Brown</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1900



3138

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED.		
COUNTY <u>Montgomery</u>	MARYLAND		STATE	COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Bethesda</u>)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>District of Columbia</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5721 Grosvenor Lane - Pearson Sanitarium</u>			STREET ADDRESS (If rural give location) <u>4405 Warren St NW.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
<u>Kathleen Wood</u>			<u>March 24 1956</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>May 3, 1898</u>		
			9. AGE last birthday: <u>77</u> yrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gov't Worker</u>		11. BIRTHPLACE (State or foreign country): <u>Decorah Iowa</u>	
13. FATHER'S NAME: <u>Thomas B. Wood</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Sadie W. Porter (Same)</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>					<u>1 day</u>
ANTECEDENT CAUSE (B) <u>Cardiovascular Decompensation</u>					<u>6 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis + myocardine degeneration 3 yrs.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan <u>1954</u> , to <u>Mar. 24, 1956</u> , that I last saw the deceased alive on <u>3/24</u> , 1956, and that death occurred at <u>6:22 PM</u> , from the causes and on the date stated above.					
SIGNATURE <u>[Signature]</u>		M.D. <u>4501-46TH ST., N.W. WASHINGTON, D.C.</u>		DATE SIGNED <u>3/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>3/27/56</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>PRINCE GEORGES MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-27-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>S.H. HINES CO.</u>		ADDRESS <u>2901-14th ST NW WASH D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. GOVERNMENT

PRINTED AT THE
GOVERNMENT PRINTING OFFICE

3139

03114

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Maryland</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Kensington</u>				STREET ADDRESS (If rural, give location)		ADDRESS <u>3901 Hampton St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Eugene Woods				Mar 15 1956			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Nov. 13, 1892</u>	
9. AGE last birthday: <u>63</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE - (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Marshall Turner</u>				14. MOTHER'S MAIDEN NAME: <u>Bea Dangerfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:		17. INFORMANT'S ADDRESS: <u>Joseph Wood. 3901 Hampton St. Kensington, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u>				DUE TO			
Antecedent cause(s) (b) <u>Hypertension</u>				DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)				3 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank G. Broschart</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				24. FUNERAL DIRECTOR ADDRESS			
DATE REC'D BY LOCAL REG. <u>3-14-56</u>		REGISTRAR'S SIGNATURE <u>Francis Teller</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert L. Snowden - Rockville, Md</u>			
DATE THEREOF <u>3-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		LOCATION (City, town, or county) (State) <u>Forest Glen, Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3140

CERTIFICATE OF DEATH

03115

Reg. Dist. No. 277

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Derwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS RFD			
3. NAME OF DECEASED (Type or print) Edgar First Brewer Middle Worley Last				4. DATE OF DEATH March 19 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 27, 1983	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stock Room Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Nevans Worley				14. MOTHER'S MAIDEN NAME Sue Magruder Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. 216-221532		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 day 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/19/56 to 3/19/56 , that I last saw the deceased alive on 3/19/56 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird				ADDRESS (Street, city or town, state) DATE SIGNED March 22 1956			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR 22 1956		22c. NAME OF CEMETERY OR CREMATORY LOVDEN PARK		22d. LOCAT ON (C'ty, town, or county) (State) Baltimore 29 1956	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Lodenville 109		24a. REC'D BY REGISTRAR DATE 3-21-56	
				24b. REGISTRAR'S SIGNATURE Lestrade B Lawley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	STATE <u>md</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Alta Vista Rest Home</u>	LENGTH OF STAY (in this place) <u>5 yrs 8 mo</u>	STREET ADDRESS (If rural give location) <u>9517 Old Georgetown Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Emma W Thright</u>		<u>Mar. 14 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed Oct. 21, 1957</u>	8. DATE OF BIRTH
		9. AGE last birthday <u>98</u> yrs.	10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ct Home</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
13. FATHER'S NAME: <u>George Thilson</u>		14. MOTHER'S MAIDEN NAME: <u>Marion Plowman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT & ADDRESS: <u>Mrs. Bessie Thright Bethesda Md. 9700 Old Georgetown Rd.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE <u>arteriosclerotic cardiovascular disease</u>		<u>YEARS</u>	
(B) ANTECEDENT CAUSE (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JAN</u> , 19 <u>54</u> , to <u>MAR</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAR 14, 1956</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Edw. E. S. Lantz</u>		DATE SIGNED <u>3/14/56</u>	
M. D. <u>8025 HARBORVIEW RD Bethesda Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/17/56</u>	<u>Glenwood</u>	<u>Washington DC</u>
DATE REC'D BY LOCAL REGISTRAR <u>8-15-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>The S. J. Davis Co.</u>	ADDRESS <u>2901-Fourteenth St. Washington (9) D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>7930 Georgetown Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>George</u> Last <u>Yendell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-80</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>	
11. BIRTHPLACE (State or foreign country) <u>Devonshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Yendell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Estelle Y. Cohed</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Massive Gastro-Intestinal</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Cecum</u> DUE TO (c) <u>Adeno Carcinoma Pancreas</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u> <u>3 Mo.</u> <u>9 Mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>18 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 March</u> , 19 <u>56</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18 March 1956</u> DATE SIGNED			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>7936 Georgetown Rd. Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		<u>7936 Georgetown Rd. Bethesda Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>3/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Union Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Westchester Co. Rye N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>3-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beaie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3528

BUREAU V. S.

MAR 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3017

CERTIFICATE OF DEATH

Reg. Dist. No. 223

03118

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 75 WASHINGTON SA. & HOSPITAL		d. STREET ADDRESS GEORGIA AVE. AT D. C. LINE 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle ALBERT Last YOST, SR.		4. DATE OF DEATH Month March Day 23 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 5, 1883
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY MD. NAT'L. CAP. PK. & PLANNING COMM.	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD YOST		14. MOTHER'S MAIDEN NAME JODY BELT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. EDWARD E. YOST, 10,604 HUNTLEY PL.		Address SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Surgical Transurethral Resection of Prostate INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8-10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Dec, 1955, to 23 March, 1956, that I last saw the deceased alive on 22 March, 1956, and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.B. Queen 7112 Willow Ave M.D. Takoma Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/26/56	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 3/16/56		24b. REGISTRAR'S SIGNATURE Wilson Dodd	

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	